# MEDICARE COVERAGE FOR MAMMOGRAPHY EXAMINATIONS

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## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

NOVEMBER 3, 1987

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# MEDICARE COVERAGE FOR MAMMOGRAPHY EXAMINATIONS

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TUESDAY, NOVEMBER 3, 1987

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
*Washington, DC.*

The subcommittee met, pursuant to call, at 1:45 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
OCTOBER 26, 1987

PRESS RELEASE # 18
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

## THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON MEDICARE COVERAGE FOR MAMMOGRAPHY EXAMINATIONS, TO BE HELD ON TUESDAY, NOVEMBER 3, 1987

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The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will conduct a hearing on Medicare coverage for mammography examinations. The hearing will be held on Tuesday, November 3, 1987 beginning at 1:00 p.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "Providing Medicare coverage for preventive procedures, like mammograms, makes very good sense both from health policy and cost perspectives. I intend to introduce legislation before the hearing date to provide Medicare reimbursement for an annual mammogram."

The hearing will focus on Chairman Stark's bill and bills introduced by Mrs. Collins, et al (H.R. 540), Ms. Oakar and Ms. Pelosi (H.R. 2935), and Mr. Robinson, et al (H.R. 2482).

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for inclusion in the printed record of the hearing.

### BACKGROUND

Medicare does not now pay for mammography because it is a preventive service and Medicare in general does not cover preventive services.

In 1987, according to the Office of Technology Assessment (OTA), approximately 110,000 women will be diagnosed to have new primary cases of breast cancer, and approximately 47,000 deaths from breast cancer will occur. About 48,000 (48 percent) of the new primary cases and about 24,000 of the deaths will occur in women over age 65.

Although epidemiological evidence has suggested a number of risk factors for breast cancer, the cause of the disease is not known. Early detection is the best means of preventing the debilitation and death associated with this disease. Computer enhancement of low-dose X rays has made the mammogram procedure for detection of breast cancer both safe and effective. An annual mammogram is now recommended for all women over 50 years of age.

Currently less than 15 percent of older women receive a mammogram in any year. Experts estimate that thousands of premature deaths due to breast cancer could be eliminated if all older women would be screened each year.

(MORE)

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, November 20, 1987, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

## COMMITTEE ON WAYS AND MEANS FORMATTING REQUIREMENTS FOR PRINTING OF HEARING STATEMENTS, WRITTEN COMMENTS AND EXHIBITS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman **Stark**. The Subcommittee on Health will commence its hearing.

I apologize for the delay, but there was some important committee business involving the Republicans and the chairman of the full committee which has necessitated this. I apologize to the witnesses.

For the members' edification, at least the first few here to the Chair's right, I would point out the microphones attached to your other microphones are alive and are part of the television recording procedure, so asides should be weighed because microphone switches will not turn them off.

Today we are going to focus on legislation introduced by myself and other Members of Congress to provide Medicare coverage for mammography screenings.

Medicare does not now cover these preventive medical services, and this appears to make no sense. As Ben Franklin had said, "An ounce of prevention is worth a pound of cure."

Early detection of breast cancer through relatively inexpensive mammogram examinations can prevent the need to spend thousands of dollars on subsequent hospital costs.

According to the Office of Technology Assessment, approximately 110,000 women will be diagnosed to have new primary cases of breast cancer, and approximately 47,000 deaths from breast cancer will occur in 1987.

Mammography is the best method for early detection and treatment of breast cancer. Studies show that deaths from breast cancer are 30 percent lower among women who have had mammography exams than among those who have not been screened.

The American Cancer Society is currently recommending that women receive a baseline mammogram between the ages of 35 and 40 and beginning at the age of 40, every 1 or 2 years until the age of 50. From age 50 and thereafter, they recommend one annual mammogram.

My legislation, H.R. 3573, would follow the American Cancer Society's guidelines. The cost of this legislation is estimated to be about $200 million a year. I would like to emphasize that when this proposal is considered, it will be reported in a budget-neutral manner.

Although this legislation only covers mammogram screenings, I am equally concerned about Medicare coverage for other preventive services, especially Pap tests.

I have requested the Office of Technology Assessment (OTA) to conduct a study to determine the effectiveness of covering a number of preventive services for Medicare beneficiaries and I plan to introduce more legislation in this area based on the results of the OTA study.

Needless deaths and debilitation can be prevented by early detection of breast cancer through mammogram screenings. The time has come for us to broaden our definition of medical care to include actions that prevent the occurrence of disease and disability. It makes sense for Medicare to begin covering preventive procedures.

I would hasten to add that it will be our intention, or at least the Chair's intention, insofar as we are able, to see that we do not create any great financial windfalls in this. We have all seen that once we begin to open up increased services, we get tremendous increased costs. We are also laboring under the budget problems of not getting scored or credit for long-term savings. That, I am afraid, is something we are going to have to take on faith and look for offsetting savings in other parts of the program. So it is with full recognition that this could be a very expensive program.

I would hope that the committee members will join with me and the witnesses in trying to ascertain if the long-term savings will be such that we can proceed with this legislation in the light of current budget concerns.

[Chairman Stark's opening statement follows:]

## OPENING STATEMENT
### REP. FORTNEY H. (PETE) STARK
### HEARING ON
### MEDICARE COVERAGE FOR MAMMOGRAPHY

Today's hearing will focus on legislation introduced by myself and other Members of Congress to provide Medicare coverage for mammography screenings.

Currently, the Medicare program does an excellent job of covering new curative procedures and technologies. As these medical discoveries are made available the Health Care Financing Administration (HCFA) includes them in the Medicare program without requiring Congressional approval. This system makes a great deal of sense. In this way Medicare beneficiaries become entitled to the most up-to-date medical curative procedures available in the country.

However, when it comes to preventive medical procedures, the story is very different. In general, Medicare does not now cover preventive medical services. As a result, these services are not provided through administrative procedures. Instead Congress must provide statutory authority.

This system makes no sense because as Ben Franklin said long ago, an ounce of prevention is worth a pound of cure.

For example, early detection of breast cancer through relatively inexpensive mammogram examinations can prevent the need to spend thousands of dollars on hospital costs for patients dying of breast cancer.

In 1987, according to the Office of Technology Assessment (OTA), approximately 110,000 women will be diagnosed to have new primary cases of breast cancer, and approximately 47,000 deaths from breast cancer will occur.

Breast cancer tends to strike older women. Almost fifty percent of all breast cancers occur in women over the age of 65. However, the survival rate for older women who are treated is as good as it is for young women.

Mammography is the best method for early detection of breast cancer, when it is most likely to be curable. Studies show that deaths from breast cancer are up to 30 percent lower among women who have had mammography than among those who have not been screened.

The American Cancer Society is currently recommending that women receive a baseline mammogram between the ages of 35 and 40 and that beginning at the age of 40, a mammogram be taken every 1 to 2 years until the age of 50. From age 50 and thereafter one is recommended annually.

My legislation, H.R. 3573, would follow the American Cancer Society's guidelines. For Medicare beneficiaries 65 and over, Medicare would be required to pay for on an annual mammogram screening on an assignment related basis.

For disabled beneficiaries, Medicare would be required to pay on an assignment related basis for a mammogram baseline screening at age 35 through 40. For disabled beneficiaries age 40 through 49, Medicare would pay for a mammogram every two years or one year if the beneficiary was in a high risk category and for those 50 and over for an annual mammogram.

Because of on going research on appropriate screening guidelines, this payment schedule may need to be revised.

To assure that Medicare beneficiaries receive the highest quality of care, my bill requires the Secretary to establish conditions of participation for facilities offering mammography procedures. Only those facilities meeting these standards and employing qualified personnel will be reimbursed.

Payment for mammogram screenings would be limited to 80 percent of the reasonable charge, up to a limit of $50 for the performance and interpretation of the mammogram. In other words, Medicare beneficiaries would never be charged more than Medicare's 20 percent coinsurance amount for the mammogram screening.

The cost of this legislation is estimated to be about $200 million a year. Let me emphasize that when this proposal is considered it will be reported in a budget neutral manner.

Although this legislation only covers mammogram screenings I am equally concerned about Medicare coverage for other preventive services, especially Pap tests.

I have requested the Office of Technology Assessment (OTA) conduct a study to determine the effectiveness of covering a number of preventive services for Medicare beneficiaries and plan to introduce more legislation in this area based on the results of the OTA study.

Needless deaths and debilitation can be prevented by early detection of breast cancer through mammogram screenings. The time has come for us to broaden our definition of medical care to include actions that prevent the occurrence of disease and disability. It makes sense for Medicare to begin covering preventive procedures.

Chairman **Stark**. Our first witnesses today are two of our colleagues, Hon. Mary Rose Oakar from Ohio, who has long been a leader in the concerns of women's issues and health issues in this country, and Hon. Tommy Robinson of Arkansas, whose concern he is sharing with the committee today.

I would ask you to present your testimony in the order that you appear on the witness list. Without objection, your prepared statements, if they are submitted, will be in the record in their entirety. You may expand or explain or elaborate on your testimony in any manner you are comfortable.

Mary Rose, welcome.

## STATEMENT OF HON. MARY ROSE OAKAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Ms. **Oakar**. Thank you very much, Mr. Chairman and distinguished members of this excellent committee. I really appreciate your having this hearing today, and the commitment of this committee to health care and health delivery to our American people.

Mr. Chairman, members of the committee, cancer is an insidious disease, and I really believe in many ways the most feared disease of all Americans. Ultimately, of course, the goal is to devise a vaccine against cancer. Numerous scientists and immunologists and health providers are working in this important research, and hopefully will find a cure for cancer and a vaccine for cancer.

But, Mr. Chairman, as Americans, we do not really provide preventive health care. We have very few health policies that provide, for example, free physicals, including cancer screening. I think Medicare is a good example of a program that does not provide prevention. You have to prove that you have high blood pressure in order to get a free blood pressure check. Medicare doesn't provide free physicals. It does not provide cancer screening, colon and pancreas screening, mammograms for women, and we could go on and on about the need for preventive health care.

But, Mr. Chairman, the purpose of your hearing today is to specifically discuss cancer screening related to breast cancer. Let me state, however, that interrelated to this vital issue, and I think it is important to state this at this time, is the entire issue of options for women with respect to cancer surgery, and the need to educate women and their families about their options. I believe that if the important studies, which I would be happy to submit for the record, if you are interested, related to choices of treatment for breast cancer were known, some of the fears of this disease would be removed, and more women would seek treatment earlier.

I have introduced a bill, H.R. 671, that relates to informed consent, and basically all a physician would have to do is give to the patient the pamphlet that NIH has put out with respect to the options women have. Nancy Reagan, I think, chose an option that was somewhat conservative, but it was her choice, and she knew what options she had. Most women really are not as informed as we would like them to be.

Mr. Chairman, I believe that over the last 20 years, breast cancer has increased as a kind of epidemic. Twenty years ago, 1 of 20 women were afflicted with breast cancer. Today the incident rate has doubled. The American Cancer Society says that it is 1 in 10. Other statistics show that 1 in 9 women are afflicted; 1.5 million women go to see a physician about a problem, a lump, something of that nature that they may have related to their breasts. More than 40,000, as you have stated, will die of breast cancer; 130,000 will develop breast cancer this year.

I don't think there is a woman in America that doesn't fear the disease. I know in my own family, members have been afflicted by the disease. Indeed our last three First Ladies have been stricken; Betty Ford was treated for breast cancer. She had the more radical surgery performed. Roselyn Carter had a benign lump removed. Her mother-in-law died of breast cancer. Nancy Reagan recently, as we know, had her left breast removed. Breast cancer doesn't know boundaries. It doesn't respect income levels, ethnic distinctions or social standings.

It is, in addition, an extraordinarily expensive disease. Approximately $2.6 billion—and I think that is conservative, I have seen much higher figures, but we chose to use the conservative figure—were spent last year, of which Medicare was charged $223 million in 1985, and this amount only represents in-patient costs. It does not represent comprehensive costs which would total up to $600 million in my judgment.

I have introduced some bills, Mr. Chairman, including a wonderful pilot project related to mammography that I was happy to work on with your staff, that relate to prevention and comprehensive coverage which I really believe should be the ultimate goal of Medicare.

While we don't have a vaccine, we do know that early treatment results in greatly reduced mortality rates. I am relieved, as all Americans are, that Nancy Reagan received early treatment. Self-examination could not detect her breast cancer, but a mammogram did, and now she has assurance of 95 to 100 percent cure rate. Dr. John Martin, a mammography specialist at the University of Texas, said it well. He said:

> The real news here is that having regular mammograms helped cure her of this disease. This is the message that should go out to thousands of women in this country.

The point really is, as you have mentioned, Mr. Chairman, in your testimony, we believe that you can reduce mortality rates by as much as 30 percent, and I have included for the record, several studies that show that you can decrease, reduce the mortality rate, and they are very, very impressive studies.

The real question is, why don't more women take advantage of mammography? The real answer is very simple, they can't afford it. We know, for example, that as an older woman living on the median-income Social Security check, she is receiving $399 a month. We know that mammograms, depending on the volume and the numbers who are able to receive mammograms, range from $35 to $200. We also know that in some parts of the country they even charge as much as $350, so the best estimate is about $100 for a mammogram, which could be reduced.

Older women live pretty much on that Social Security check. Only 20 percent have any other source of income, so when you are asking an older person to take one fourth of their monthly income for a mammogram, you are asking them to choose between that kind of prevention and possibly food or shelter. And so what we really need, Mr. Chairman—I don't like to use it, I have it in my testimony, but I don't like to use the word "expand" Medicare. I think you should almost look at this as preventing and not expanding Medicare. We ought to look at this as a way that you could lessen the expansion, because there would be less need, in my judgment, for catastrophic surgery and followup.

Mr. Chairman, I have complete confidence in saying that mammograms will not only save lives and personal expenses, they will also eventually save the Medicare program a great deal of money, something we are all concerned about.

Typical treatment costs for women who discover breast cancer at an early stage is less than $20,000, and in contrast, treatment costs for breast cancer at its later stages can total more than $60,000. Eventual savings in treatment costs should be more than enough to offset the costs of providing the mammogram, and of course you are saving pretty much the person's life as well, which ought to be the primary consideration.

Considering the positive aspects of breast cancer screening, it was very frustrating—and I have to say this, and I know how hard some of you worked on and are working on the catastrophic bill—it was extraordinarily frustrating for me to witness the loss of an excellent opportunity to at least get something in the catastrophic bill related to screening. At one time in its formulation, the Medicare Catastrophic Prevention Act of 1987 did contain a provision that would have provided for triennial mammograms and colorectal examinations.

The amendment to the bill was introduced by our dear friend, Congresswoman Collins. She is to be congratulated, but it seems that the amendment was stricken because of, in my judgment, an extraordinarily inaccurate cost estimate. So in spite of the appearance by Congresswoman Collins and myself before the Rules Committee to allow an opportunity to amend the amendment to reinstall the bill, the final version of the bill passed by the full House did not contain the mammography provision. It was stricken because coverage is inadequate, and really older women should have annual mammograms, not one mammogram every 3 years, but that is better than nothing.

We feel strongly that we ought to go back to the Senate version, if it is possible at this late hour. I certainly want to urge the conferees to work to retain this portion of the language that is in the Senate bill. However, in spite of the small victory contained in the Senate bill, we still need to pass legislation that is really medically accurate. Triennial mammograms are really insufficient to provide ample warning for early treatment for older women, but it is more than we have now. We really need an annual mammogram, for older women, especially.

Last July I offered a bill, and, Mr. Chairman, I am delighted that you have your bill, I think it is even more comprehensive than mine, but we have a bill that would propose to amend Medicare to cover one free mammogram for women annually over the age of 65.

Also in the bill, and I have to say I think this is rather important based on the limited knowledge I have, it specifies a maximum safe dosage of radiation, the qualifications of the personnel conducting the mammogram and those interpreting the results, and the type of machinery that can be used. It does establish a $50 payment cap. We think that if you had many, many thousands of people taking advantage of this, that that would even be high, and so you could even do it for a lower amount of money.

Mr. Chairman, one of the things that is frustrating is that we at the Federal level have not gotten with it in terms of our coverage, but the fact is that certain States, too few, but States like the State of Texas, the Speaker's state, did recently pass a law that required every health insurance policy written in the State of Texas to cover women 35 years or older to include coverage for annual screening by low-dose mammography. This is the kind of legislation that really makes sense.

Mr. Chairman, for many years several of us in the room have been speaking out on the necessity for legislation to provide Medicare coverage for annual mammograms. I want to pay a special tribute to Rose Kushner, who I know is in the audience, who has had breast cancer herself. Rose has written books about it, and is always available for so many people across the country to talk about it, and she, I think, is responsible for saving a few lives as well.

I guess my question to the committee is, after our Aging Committee has had hearings, and we know a lot about this issue, if it is ultimately cheaper and it saves lives, why don't we do it. Why don't we just provide leadership for millions of American women and their families. I know they would be grateful, and I think you would be taking a tremendous step in the right direction by having a hearing by such an important committee, the Ways and Means Committee.

I really want to thank you, Mr. Chairman and members of the committee, for allowing me to speak today.

[The statement of Ms. Oakar follows:]

## TESTIMONY OF THE HONORABLE MARY ROSE OAKAR
CONGRESSWOMAN FROM OHIO

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, LADIES AND GENTLEMEN:

THANK YOU FOR CONDUCTING THIS HEARING AND FOR YOUR COMMITMENT TO HEALTH CARE AND HEALTH DELIVERY FOR OUR PEOPLE. IT IS A PLEASURE TO TESTIFY BEFORE YOU.

CANCER IS AN INSIDIOUS DISEASE AND PERHAPS THE MOST FEARED DISEASE OF ALL AMERICANS. THE ULTIMATE GOAL IS, OF COURSE, DEVISING A VACCINE AGAINST CANCER. NUMEROUS SCIENTISTS, IMMUNOLOGISTS AND HEALTH PROVIDERS ARE CONDUCTING IMPORTANT RESEARCH IN THIS AREA. WE MUST FIND A CURE FOR CANCER AND I BELIEVE THIS MUST BE OUR CLIMACTIC GOAL.

MR. CHAIRMAN, AS AMERICANS WE DO NOT PROVIDE PREVENTIVE HEALTH CARE. VERY FEW HEALTH POLICIES PROVIDE FREE PHYSICALS, INCLUDING CANCER SCREENING. THIS IS ESPECIALLY TRUE OF GOVERNMENT-INITIATED PLANS, SUCH AS MEDICARE, WHICH PROVIDES ABOUT 40 PERCENT OF AN OLDER PERSON'S NEEDS. FOR EXAMPLE, NO MEDICARE COVERAGE EXISTS FOR FREE PHYSICALS, BLOOD PRESSURE SCREENING (UNLESS ONE PROVES HE OR SHE HAS HIGH BLOOD PRESSURE), COLON OR PANCREAS SCREENING AND CERTAINLY NO FREE MAMMOGRAMS. I FAVORED THE CONCEPT OF PROVIDING PREVENTIVE MEDICAL SCREENINGS WITHIN THE CATASTROPHIC PREVENTION BILL AND KNOW OF THIS COMMITTEE'S HARD WORK ON THAT ISSUE.

MR. CHAIRMAN, THE PURPOSE OF YOUR HEARING IS TO DISCUSS CANCER SCREENING RELATED TO BREAST CANCER. LET ME BRIEFLY STATE, HOWEVER, THAT INTERRELATED TO THIS VITAL ISSUE IS THE ENTIRE ISSUE OF OPTIONS FOR WOMEN, AND THE NEED TO EDUCATE WOMEN AND THEIR FAMILIES ABOUT THESE OPTIONS. I BELIEVE THAT IF THE IMPORTANT STUDIES RELATED TO CHOICES OF TREATMENT FOR BREAST CANCER WERE KNOWN, SOME OF THE FEAR OF THIS DISEASE WOULD BE REMOVED AND WOMEN WOULD MORE READILY SEEK EARLY TREATMENT. THAT IS WHY I HAVE INTRODUCED H.R. 671 -- THE BREAST CANCER INFORMED CONSENT ACT -- THAT WOULD MANDATE THAT A PHYSICIAN MUST DISCUSS OPTIONS WOMEN HAVE IN THE TREATMENT OF BREAST CANCER -- JUST AS NANCY REAGAN HAD OPTIONS. SHE HAD THE OPTION TO MAKE A CHOICE AND SHE APPARENTLY CHOSE THE MORE CONSERVATIVE METHOD OF TREATMENT, BUT THE IMPORTANT POINT IS THAT SHE CHOSE THE TREATMENT.

MR. CHAIRMAN, OVER THE LAST 20 YEARS BREAST CANCER HAS INCREASED AS A KIND OF EPIDEMIC. TWENTY YEARS AGO, ONE OF TWENTY AMERICAN WOMEN WERE AFFLICTED BY BREAST CANCER. TODAY THE INCIDENCE RATE HAS MORE THAN DOUBLED. THE AMERICAN CANCER SOCIETY RECENTLY REVISED THEIR ESTIMATES UPWARD TO ONE OF 10 WOMEN -- OTHER STUDIES ESTIMATE ONE OF NINE WOMEN ARE AFFLICTED. MORE THAN 130,000 WOMEN WILL HAVE DEVELOPED BREAST CANCER BY THE END OF THIS YEAR, AND ALMOST 40,000 WILL HAVE DIED. INDEED, OUR LAST THREE FIRST LADIES MIRROR AMERICAN WOMEN. BETTY FORD WAS TREATED FOR BREAST CANCER; ROSALYN CARTER HAD A BENIGN LUMP REMOVED (HER MOTHER-IN-LAW DIED OF IT); AND NANCY REAGAN HAD HER LEFT BREAST REMOVED. BREAST CANCER KNOWS NO BOUNDARIES -- IT DOES NOT RESPECT INCOME LEVELS, ETHNIC DISTINCTIONS OR SOCIAL STANDING. IT IS, IN ADDITION, AN EXTRAORDINARILY EXPENSIVE DISEASE -- APPROXIMATELY $2.6 BILLION WAS SPENT LAST YEAR, OF WHICH MEDICARE WAS CHARGED $223 MILLION IN 1985. THIS AMOUNT REPRESENTS ONLY AN ESTIMATE OF INPATIENT COSTS. TOTAL MEDICARE PAYMENTS ARE UNDOUBTEDLY MUCH MORE.

THAT IS WHY I HAVE INTRODUCED H.R. 678, H.R. 679, AND H.R. 680, WHICH DEAL WITH VARIETIES OF PREVENTIVE AND COMPREHENSIVE COVERAGE. MR. CHAIRMAN, WE COULD SAVE LIVES AND MONEY IF WE PROVIDED COVERAGE THAT IS COMPREHENSIVE. I DO, HOWEVER, UNDERSTAND THE FINANCIAL AND POLITICAL REALITIES OF PROVIDING SUCH COMPREHENSIVE SERVICES. IN SPITE OR THESE OBSTACLES, I REMAIN ADAMANT IN MY BELIEF THAT COMPREHENSIVE CARE WILL PROVE TO EVENTUALLY SAVE THE MEDICARE TRUST FUND A GREAT DEAL OF MONEY.

WHILE WE HAVE NOT YET DEVELOPED A VACCINE, WE DO KNOW THAT EARLY TREATMENT RESULTS IN A GREATLY REDUCED MORTALITY RATE. I AM SO GREATLY RELIEVED THAT NANCY REAGAN RECEIVED EARLY TREATMENT. SELF EXAMINATION COULD NOT DETECT HER BREAST CANCER, BUT A MAMMOGRAM DID. SHE HAS ASSURANCE OF A 95-100 PERCENT CURE. DR. JOHN MARTIN, A MAMMOGRAPHY SPECIALIST AT THE UNIVERSITY OF TEXAS STATED, "THE REAL NEWS HERE IS THAT HAVING REGULAR MAMMOGRAMS HELPED CURE HER OF THIS DISEASE. THAT IS THE MESSAGE THAT SHOULD GO OUT TO THOUSANDS OF WOMEN IN THIS COUNTRY".

MR. CHAIRMAN, IT IS AN ESTABLISHED FACT THAT MAMMOGRAPHY CAN REDUCE THE MORTALITY RATE OF BREAST CANCER VICTIMS. SEVERAL SCIENTIFIC STUDIES CONDUCTED BY RESPECTED ORGANIZATIONS HAVE SHOWN CONCLUSIVELY THAT MAMMOGRAPHY CAN REDUCE THE MORTALITY RATE BY AS MUCH AS 30%.

FOR EXAMPLE, THE HEALTH INSURANCE PLAN OF GREATER NEW YORK HAS CONDUCTED A STUDY FOR OVER 20 YEARS WHICH SHOWS THAT THE USE OF REGULARLY OBTAINED MAMMOGRAMS CAN LOWER THE DEATH RATE BY 30%. GIVEN THE PAIN-STAKING ATTENTION TO SCIENTIFIC DETAIL THE ORGANIZERS OF THE STUDY HAVE APPLIED TO THE EFFORT, THERE IS NO DOUBT AS TO THE SCIENTIFIC VALIDITY OF THE STUDY OR ITS CONCLUSIONS. THE PRACTICAL TRANSLATION OF THIS STUDY IS THAT WE CAN SAVE AT LEAST 12,000 LIVES EVERY YEAR IF MAMMOGRAMS ARE EMPLOYED.

ANOTHER STUDY, CONDUCTED BY THE AMERICAN CANCER SOCIETY, REPORTS THE FOLLOWING: "VERY HIGH SURVIVAL RATES HAVE BEEN OBSERVED IN FOUR THROUGH 11 YEARS OF FOLLOW-UP IN 4,240 WOMEN WITH A HISTOLOGICALLY CONFIRMED DIAGNOSIS OF BREAST CANCER IN THE BREAST CANCER DETECTION DEMONSTRATION PROJECT. THE RELATIVE FIVE, EIGHT, AND 10-YEAR SURVIVAL RATES WERE 88, 83, AND 79 PERCENT RESPECTIVELY".

THE RESULTS OF OTHER STUDIES ARE EQUALLY IMPRESSIVE.

AT THIS POINT, THE ONLY QUESTION THAT HAS NOT BEEN ASKED IS: WHY HAVEN'T MORE WOMEN TAKEN ADVANTAGE OF MAMMOGRAPHY IN ORDER TO ALLEVIATE THEIR FEARS? THE PRIMARY ANSWER TO THAT QUESTION IS THAT MILLIONS OF WOMEN CAN'T AFFORD IT. THIS IS PARTICULARLY TRUE OF OLDER WOMEN.

REPEATED QUERIES BY MY STAFF AND THE EFFORTS OF OTHER INTERESTED GROUPS HAVE REVEALED THAT MAMMOGRAMS RANGE IN COST FROM $35 TO $200. HOWEVER, THE BEST GUESS AVAILABLE IS THAT THE AVERAGE COST IS APPROXIMATELY $100. WHEN THIS FACT BECOMES KNOWN, IT IS EASY TO UNDERSTAND WHY AN ELDERLY WIDOW WHO BRINGS HOME LESS THAN $400 PER MONTH IN SOCIAL SECURITY CHECKS DOES NOT RECEIVE AN ANNUAL MAMMOGRAM. WHEN FACED WITH THE DECISION OF SPENDING ONE QUARTER OF A MEAGER MONTHLY INCOME TO BUY FOOD OR TO BUY A MAMMOGRAM, THE CHOICE BECOMES OBVIOUS.

MR. CHAIRMAN, WHAT IS DESPERATELY NEEDED IS AN EXPANSION OF THE MEDICARE PROGRAM THAT WILL COVER THE EXPENSE OF ANNUAL MAMMOGRAMS. WE NEED TO PROVIDE A MEANS FOR WOMEN POSSESSING MODEST FINANCIAL RESOURCES TO AFFORD QUALITY MAMMOGRAMS. THE LIVES AND FINANCIAL SOLVENCY OF MANY WOMEN DEPENDS UPON RAPID CONGRESSIONAL ACTION.

IN ADDITION, I HAVE COMPLETE CONFIDENCE IN SAYING THAT MAMMOGRAMS WILL NOT ONLY SAVE LIVES AND PERSONAL EXPENSES, THEY WILL ALSO EVENTUALLY SAVE THE MEDICARE PROGRAM A GREAT DEAL OF MONEY. TYPICAL TREATMENT COSTS FOR WOMEN WHO DISCOVER BREAST CANCER AT AN EARLY STAGE IS APPROXIMATELY $20,000. IN CONTRAST, TREATMENT COSTS FOR BREAST CANCER IN ITS LATER STAGES CAN TOTAL $60,000 OR MORE. THE EVENTUAL SAVINGS IN TREATMENT COSTS SHOULD BE MORE THAN ENOUGH TO OFFSET THE COSTS OF PROVIDING THE MAMMOGRAMS.

CONSIDERING THE POSITIVE ASPECTS OF BREAST CANCER SCREENING, IT WAS ESPECIALLY FRUSTRATING FOR ME TO WITNESS THE LOSS OF AN EXCELLENT OPPORTUNITY LAST SUMMER TO PROVIDE LIMITED SCREENING. AT ONE TIME IN ITS FORMULATION, THE MEDICARE CATASTROPHIC PREVENTION ACT OF 1987 CONTAINED A PROVISION THAT WOULD HAVE PROVIDED FOR TRIENNIAL MAMMOGRAMS AND COLORECTAL EXAMINATIONS. THIS AMENDMENT TO THE BILL WAS INTRODUCED AND CHAMPIONED BY OUR FRIEND AND COLLEAGUE, CARDISS COLLINS. HOWEVER, IT SEEMS THE AMENDMENT WAS STRICKEN BECAUSE OF AN INACCURATE COST ESTIMATE.

IN SPITE OF AN APPEARANCE BY CARDISS COLLINS AND I BEFORE THE RULES COMMITTEE TO ALLOW AN OPPORTUNITY TO AMEND THE BILL TO REINSTALL THIS PROVISION, THE FINAL VERSION OF THE BILL PASSED BY THE FULL HOUSE DID NOT CONTAIN THE MAMMOGRAPHY PROVISION. IT WAS STRICKEN IN SPITE OF THE FACT THAT THE COVERAGE WAS MEDICALLY INADEQUATE SINCE IT DID NOT COVER ANNUAL MAMMOGRAMS, BUT ONE MAMMOGRAM EVERY THREE YEARS. THIS IS IN DIRECT CONTRADICTION TO THE POLICY OF THE AMERICAN CANCER SOCIETY WHICH PROMOTES A POLICY OF ONE MAMMOGRAM EVERY YEAR FOR OLDER WOMEN UNLESS OTHERWISE SPECIFIED BY THE PATIENT'S PHYSICIAN.

IN SPITE OF THIS DISAPPOINTMENT, IT SEEMS WE HAVE A SECOND CHANCE TO PASS A BREAST CANCER SCREENING PROVISION DURING THE CONFERENCE OF THE MEDICARE CATASTROPHIC PREVENTION ACT OF 1987. THE SENATE PASSED ITS VERSION AND IT CONTAINS LANGUAGE SPECIFYING TRIENNIAL MAMMOGRAMS SIMILAR TO THE LANGUAGE CONTAINED IN THE ORIGINAL HOUSE VERSION. I URGE ALL HOUSE CONFEREES TO WORK TO RETAIN THIS PORTION OF THE LANGUAGE IN THE SENATE BILL.

HOWEVER, IN SPITE OF THE SMALL VICTORY CONTAINED IN THE SENATE BILL, WE STILL NEED TO PASS LEGISLATION THAT IS MEDICALLY CORRECT. TRIENNIAL MAMMOGRAMS ARE INSUFFICIENT TO PROVIDE AMPLE WARNING FOR EARLY TREATMENT FOR OLDER WOMEN. WE MUST HAVE ANNUAL MAMMOGRAMS IN ORDER TO SAFELY ENSURE THE HEALTH OF OLDER WOMEN.

LAST JULY, I OFFERED A BILL THAT WOULD ACT AS A GOOD STARTING POINT TOWARD THAT GOAL. MY BILL, H.R. 2935, PROPOSES TO AMEND MEDICARE TO COVER ONE FREE ANNUAL MAMMOGRAM FOR ALL WOMEN OVER THE AGE OF 65 YEARS. IN ADDITION, IT CAREFULLY PROVIDES SEVERAL MEDICALLY CORRECT PROVISIONS. FOR EXAMPLE, IT SPECIFIES A MAXIMUM SAFE DOSAGE OF RADIATION, THE QUALIFICATIONS OF THE PERSONNEL CONDUCTING THE MAMMOGRAPH AND THOSE INTERPRETING THE RESULTS, AND THE TYPE OF MACHINERY THAT CAN BE USED. IT ALSO ESTABLISHES A $50 PAYMENT CAP. THIS IS A CORRECT, REALISTIC PROPOSAL THAT CAN SAVE LIVES AND TAX DOLLARS.

MR. CHAIRMAN, I HAVE FOUND THAT ONE OF THE MOST FRUSTRATING AN EMBARRASSING ASPECTS OF THIS ISSUE IS THAT ONCE AGAIN, THE STATES ARE LEADING THE FEDERAL GOVERNMENT. FOR EXAMPLE, THE SPEAKER'S OWN GREAT STATE OF TEXAS RECENTLY PASSED A LAW, S.B. 1371. THIS LAW REQUIRES EVERY HEALTH INSURANCE POLICY WRITTEN IN THE STATE OF TEXAS TO COVER WOMEN 35 YEARS OLD OR OLDER TO "INCLUDE COVERAGE FOR AN ANNUAL SCREENING BY LOW-DOSE MAMMOGRAPHY FOR THE PRESENCE OF OCCULT BREAST CANCER...". THIS IS A WONDERFULLY PROGRESSIVE, HUMANE LAW.

THIS KIND OF LEGISLATION MAKES SENSE. HEALTH CARE PREVENTION SERVICES SHOULD BECOME A CENTRAL THEME OF ALL HEALTH CARE POLICY. WE NEED TO PASS LEGISLATION THAT WILL PROVIDE COVERAGE FOR ALL TYPES OF CANCER SCREENING. IN PARTICULAR, IF WE ARE TRULY SERIOUS ABOUT SAVING LIVES FROM THE THREAT OF CANCER, THE CONGRESS MUST ACT IMMEDIATELY TO AMEND MEDICARE TO REFLECT THAT GOAL. I URGE ALL MEMBERS OF CONGRESS TO BEGIN SUCH CONSIDERATION.

MR. CHAIRMAN, FOR MANY YEARS, SEVERAL OF US IN THIS ROOM HAVE BEEN SPEAKING OUT ON THE NECESSITY FOR LEGISLATION TO PROVIDE MEDICARE COVERAGE FOR ANNUAL MAMMOGRAMS. WE KNOW THAT IF MEDICARE INCLUDED BREAST CANCER SCREENING, PRIVATE HEALTH PLANS WOULD FOLLOW, AND THE COST OF A MAMMOGRAM WOULD GO DOWN. IN ADDITION, IT IS OBVIOUS THAT THE SURVIVAL RATE WOULD INCREASE DRAMATICALLY.

OUR SELECT COMMITTEE ON AGING, SUBCOMMITTEE ON HEALTH AND LONG TERM CARE, OF WHICH I AM A MEMBER, HAS HELD COMPREHENSIVE HEARINGS THAT HAVE BEGUN THE PROCESS TO PROVIDE THE OPPORTUNITY FOR ALL WOMEN TO AFFORD A MAMMOGRAM. IT IS TIME TO ACT IN ORDER TO CALM THE FEAR HELD BY SO MANY AMERICAN WOMEN. THE LIFE-THREATENING EFFECTS OF BREAST CANCER CAN BE CONTROLLED. WE CAN DO THAT IF WE CONTINUE TO HAVE THE COURAGE TO ACT PROPERLY. WE SINCERELY APPRECIATE YOUR EFFORTS AND APPLAUD YOUR LEADERSHIP. MILLIONS OF AMERICAN WOMEN AND THEIR FAMILIES WILL BE GRATEFUL IF WE INCLUDE MAMMOGRAPHY IN MEDICARE COVERAGE.

THANK YOU.

Chairman **Stark**. I want to thank the gentlelady for her contribution.

If you will suspend for a moment, we will hear from Mr. Robinson and then the committee will inquire of both of you.

## STATEMENT OF HON. TOMMY F. ROBINSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. **Robinson**. Mr. Chairman, I would like to thank you for giving me this opportunity to testify before your committee today. As you know, my bill, H.R. 2482, would provide Medicare reimbursement for annual mammograms, the screening procedure used to detect breast cancer, and pap smears. As you stated earlier, "an ounce of prevention is worth a pound of cure."

The prevention of diseases is one area where Medicare coverage is sorely lacking, in my opinion. Breast cancer strikes 1 out of 10 women in America today. Each year, 40,000 women will die from this terrible disease, and thousands more will undergo extensive surgery in order to survive. What is worse is that much of this tragedy is preventable.

Furthermore, Mr. Chairman, mammograms are cost effective. Mammograms can range in cost from $65 at a breast screening clinic to $140 in a hospital setting. I ask the members to compare this with the overall costs to a patient who has terminal breast cancer, which can run in the later years of life up to $85,000 to $90,000.

An additional provision in my bill will allow Medicare coverage for mammograms when the technical component of the test is performed by a certified technician under the supervision, though not necessarily in the presence, of a physician, rather than by a physician. However, the interpretation of the tests and the reportage of results to the patient will remain the responsibility of the physician or physician radiologist. This measure will provide less expensive breast screening while not compromising quality health care in the least.

The presence of a full-time physician is unnecessary for the technical component of breast cancer screening tests and would significantly impact the cost of service. My legislation will correct this oversight in Medicare policy and will further serve to facilitate rather than hinder efforts aimed at the early detection of breast cancer.

In order to further advance the prevention of uterine cancer, my bill will help encourage regular pap tests among women for the early detection of cervical and endometrial cancer. In 1987, there will be an estimated 48,000 new cases of uterine cancer in the United States—17,000 cases of cervical cancer and 35,000 cases of endometrial cancer. Over the last 40 years, the incidence of uterine cancer has decreased by about 70 percent, primarily because of the advent and increased use of Pap smear.

The routine Pap smear has proven to be highly effective in the early detection of uterine cancer. Over 90 percent of cervical cancer cases and 50 percent of endometrial cancer cases can be diagnosed at an early stage through the use of the Pap test. As part of a routine pelvic exam, the Pap smear costs about $15, a small price to pay for peace of mind and the prevention of uterine cancer.

I am confident that with your leadership, Mr. Chairman, we can properly address the importance and value of these well-known screening tests. Hopefully, we can draft and pass legislation that will enable older women to obtain these inexpensive preventative procedures that will save lives and reduce later health care expenses and trauma by reducing the severity of breast and uterine cancer.

[The statement of Mr. Robinson follows:]

### STATEMENT OF HON. TOMMY F. ROBINSON

Mr. Chairman, I would like to thank you for giving me the opportunity to testify before your committee. As you know, my bill H.R. 2482 would provide Medicare reimbursement for annual mammograms, the screening procedure used to detect breast cancer, and pap smears, a test used to detect uterine cancer. Sixty-two of my colleagues have joined me as cosponsors of this legislation proving that many members of the House are quite serious about enabling Medicare recipients to benefit from these well known screening techniques.

As an old adage states, "an ounce of prevention is worth a pound of cure." The prevention of diseases is one area where medicare coverage is sorely lacking. In my opinion, for Medicare to continue as a viable health care policy it must take on an increased role in the advocacy of disease prevention. The whole idea of health care is to maintain a healthy citizenry that will be able to live out a productive life, free from debilitating and painful diseases.

Breast cancer strikes 1 out of 10 women in America today. Each year, 40,000 women will die from the disease and thousands more will undergo extensive surgery in order to survive. What is worse is that much of this tragedy is preventable.

The purpose of breast screening by mammography is to improve the survival of women by detecting breast cancer at an early stage. Mammograms can detect a tumor 2 to 3 years before a physician is able to by physical exam. It is a highly safe, reliable, and acceptable procedure. Mammography is capable of providing the diagnosis of breast cancer before it spreads to other parts of the body. Treatment applied at this stage can produce a cure rate in excess of 90 percent, according to the American College of Radiology.

Furthermore, mammograms are cost effective. Mammograms can range in cost from $65.00 at a breast screening clinic to $140.00 in a hospital setting. Compare this with the overall costs to a patient who has terminal breast cancer, which can run, in the later years of life, to $80–85,000.00.

An additional provision in my bill will allow Medicare coverage for mammograms when the technical component of the test is performed by a certified radiologic technologist under the supervision (though not necessarily in the presence) of a physician, rather than by a physician. However, the interpretation of the tests and the reportage of results to the patient will remain the responsibility of the physician or physician-radiologist. This measure will provide less expensive breast screening while not compromising quality health care in the least.

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Chairman STARK. Thank you very much.

I think there is a great deal of confusion among Medicare beneficiaries. Obviously, younger Americans have to look to their own insurance policies, and I really don't know what most of those cover in terms of prevention, but certainly among Medicare beneficiaries, primarily who are seniors, I am not sure that they understand whether or not Medicare pays for these preventive services. I am also not so sure that fear isn't a big deterrent factor. I suspect it is with me.

I am a little more familiar with proctoscopic examinations, and they are not very comfortable, and I tend to avoid them. Even if the price went down I think I would avoid them, so I am not sure that some backsliding isn't involved in any of these preventive measures.

Do you think that making mammograms available, as a service that Medicare would pay, is enough?

Ms. OAKAR. I want to compliment my friend here, Tommy Robinson, for his legislation.

Mr. Chairman, I don't think it is enough. I mean, I think it is a step in the right direction, but frankly, in my judgment and in the knowledge that I have of Medicare, and frankly most health policies, unless they are HMOs, you are really dealing with the back end very often. I mean, you pay pretty much for the surgery, but you won't pay for the physical, and there are so many other areas.

I know you have some wonderful demonstration projects that ought to be covered. For example, we ought to cover colon screening for men, pancreas screening, free physicals. We ought to do something—I know you are trying to do it—in the catastrophic bill with respect to prescriptions to prevent stroke by taking medication. In the long run, it is far cheaper to do it that way.

We are just not oriented in that direction in our country. Most health policies, Mr. Chairman, to the best of my knowledge, with the exception of HMOs, are pretty much like Medicare. Try to find a health policy that is not an HMO that covers a free physical, a free mammogram, but will pay for the hospital care. It is just all backward.

Mr. ROBINSON. I think my colleague covered what I would state, very eloquently, and I have nothing else to add at this time.

Chairman STARK. I think what you do is you make a case—Dr. Roper will be glad to hear this—for capitalization, which may be the answer to the next question, how we pay for this. We run into this increasing the excise tax on cigarettes, which would have decreased the usage, but cost us in the budget, because people would quit smoking and live longer and impact on the cost of Medicare.

Now, if you chase your tail long enough, you discover that what may be some savings at one point may extend life and therefore cost the system more. I think it is going to be hard to separate, but I think this particular procedure has been so dramatically brought to the attention of the public that this might be the place to start.

I want to thank you both.

Mr. Donnelly.

Mr. **Donnelly**. Thank you, Mr. Chairman.

Let me welcome my two colleagues before the committee and congratulate them for articulating this issue.

Over the course of time, in fact prior to the recent publicity engendered by the First Lady's surgery, you have been heavily involved in this issue, and I congratulate you because this hearing is a combination of your individual collective efforts.

I just have one question in regard to the costs. The chairman's legislation would limit the reimbursement to $50 per mammogram, which would include the 20 percent co-pay. Do you think that is a fair fee for service; is it a fair reimbursement?

Ms. **Oakar**. I do. That is what I had put in the bill that I introduced.

Mr. **Donnelly**. It is in your legislation too?

Ms. **Oakar**. I don't know if he is on your witness list, to be honest, I didn't get a chance to look at it closely, but Dr. Strax in New York has a clinic, if I am not mistaken, and I think they charge between $25 and $30 for a mammogram, which is a proper one, and so forth. In New York we all know the expenses are a little higher than in some other parts of the country, so I think that is very fair. If you have more people taking advantage of it, and you don't burden the cost of the system by all this unnecessary surgery, that you could prevent, you could ultimately save a lot more money in medical dollars.

Mr. **Donnelly**. Tommy.

Mr. **Robinson**. The American Cancer Society has stated that a cost assignment of $50 is a reasonable price for a mammogram, and $7 for a pap smear.

The one area in my legislation that we failed to take a real close look at was the long-term cost, and I think we can resolve that by mandatory cost assignments. I think $50 is a fair reimbursement for the test.

Mr. **Donnelly**. CBO estimates that it would increase utilization threefold, both Mary Rose's legislation and the chairman's legislation, as well as that of the gentleman from Arkansas, so it seems to me that increased utilization ought to reduce the cost, and I just want to get on the record that you are supportive of the $50 cap.

Thank you again.

Ms. **Oakar**. You know what you have to ask CBO to do. At one point I think we did ask them to do it. You have to ask them what they estimate the lack of breast cancer surgery will be. What is the savings on that, because you get people to take mammograms, to have those kinds of exams. Over a period it is a lot of money. It costs a lot of money to have all that surgery.

Mr. **Donnelly**. It is just my personal opinion, and you may disagree with this, but as we expand Medicare, in whatever way we do that, we should build in some cost controls. That is why I am very supportive of a $50 cap. I think it is a reasonable fee.

Thank you, Mr. Chairman, for yielding.

Chairman **Stark**. Before I recognize Mr. Coyne, I am sorry to be so late with this, but we do have a CBO cost estimate that is being copied, and I think passed out to the members, and I would ask unanimous consent that it be included in the record. I think you each have it now. I apologize to the witnesses for not making this available earlier.

[The CBO cost estimate follows:]

November 2, 1987

**CONGRESSIONAL BUDGET OFFICE**
**U.S. CONGRESS**
**WASHINGTON, D.C. 20515**

## POTENTIAL COSTS ASSOCIATED WITH MEDICARE COVERAGE OF ANNUAL SCREENING MAMMOGRAMS

Four bills currently propose Medicare coverage of annual screening mammograms -- a test in which low doses of radiation are delivered to the breasts to provide pictures for detection of early tumors. At present, Medicare Part B covers only "diagnostic" mammography which is an exam used to determine the severity of a pre-detected cancer.

The budget effects and key features of the four bills are shown in Table 1 and Table 2. The proposed benefits range from annual mammograms and annual Pap tests for all Medicare enrollees to annual mammograms only for enrollees over age 65. H.R. 3573 and H.R. 2935 would limit reimbursement to $50 in the first year and allow the Secretary of Health and Human Services to set the payment amount in future years. In addition, H.R. 3573 would require that providers accept the Medicare payment limit as the total charge for the service. The effective date of the proposed benefits ranges from January 1, 1988 to January 1, 1989.

TABLE 1. TOTAL ESTIMATED FEDERAL OUTLAYS OF CURRENT BILLS

(by fiscal years, in millions of dollars)

| Bill | 1988 | 1989 | 1990 | 1991 | 1992 |
|---|---|---|---|---|---|
| H.R. 3573 | 0 | 95 | 205 | 250 | 270 |
| H.R. 2935 | 115 | 230 | 275 | 295 | 315 |
| H.R. 2482 1/ | 240 | 480 | 580 | 630 | 670 |
| H.R. 540 1/ | 225 | 480 | 580 | 630 | 670 |

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1/ The figures presented here are subtotals for the cost of screening mammograms only. H.R. 2482 and H.R. 540 would also include coverage of annual pap smears which bring total outlays for pap smears and mammograms to $570 million and $535 million, respectively, in 1988 with 5-year totals of $5.73 billion and $5.69 billion.

The estimated costs of each of the bills is determined by the extent of the benefits, the reimbursement amount, the utilization rate, the number of eligible enrollees, and the effective date of the legislation. These differences are discussed in the following sections.

## Average Cost of Screening Mammograms

The cost of an annual screen ranges from $35 at low-cost, high-volume screening centers to $180 at some institutions. The price depends on volume, regional cost variations, number of views included in the exam, and availability of American Cancer Society (ACS) promotional programs. Definitions of an annual screening mammogram vary and can alter significantly average costs. Based on discussions with numerous health experts, we have determined the average cost across all localities for an annual screening mammogram to be $100.

For cost estimating purposes, where a bill does not specifically define the screen exam or set a reimbursement limit, we have used an average cost of $100. H.R. 2935 defines an annual screen and limits reimbursement to $50 per screening exam. H.R. 3573 also would limit reimbursement to $50 and specify mandatory assignment, which would require providers to accept the Medicare payment limit as the total charge for the service.

## Utilization

No accurate data exist on the current utilization of annual screens. Discussions with experts at ACS, the National Cancer Institute (NCI), and the American College of Radiology produce a range of current utilization rates of between 2 and 20 percent for women over the age of 65. We use 12 percent as a reasonable estimate of current utilization.

Clearly, there will be a significant increase in utilization if annual screening mammograms are covered by Medicare. Projections of the increase in utilization which is expected to occur with Medicare coverage depend on several factors:

- Doctor's recommendations
- Patient's awareness of need
- Availability

First, doctor's recommendations for the screen appear to be the most influential utilization factor. A report by ACS highlighted this relationship. In a 1986 Gallup poll of 1156 women 40 years and older, 35 percent of the respondents reported that a doctor had at some time recommended a mammogram. Of those, 94 percent had had a mammogram in the previous two years. Of the 65 percent whose doctors never recommended a mammogram, only 35 percent had had one in the previous two years. From phone interviews with physicians, we conclude that the main reason why doctors do not recommend the screen is due to the prohibitive cost. If Medicare were to cover the screen, these physicians felt that doctors would encourage more screening and utilization would increase significantly.

Second, a lack of awareness of the importance of annual mammograms has deterred many women from utilizing them. Despite ACS and NCI recommendations that all women over age 50 should have yearly mammograms, 77 percent of the respondents in the ACS survey claimed they did not need the annual screen. Medicare coverage of annual mammograms could encourage more women to believe the test was necessary and thus increase utilization. Also, the promotion for annual screening publicized by Nancy Reagan's recent surgery is likely to increase awareness and have a positive effect on utilization, at least over the next few months.

Third, utilization will be affected by the availability of screening mammograms. In general, we assume that screening mammography is widely available to most of the eligible population. However, limits on price may limit the availability of the screening exam. For H.R. 2935, the $50 cap on reimbursement is not estimated to have a large effect on utilization because providers could recover the excess of their charges over Medicare's payment limit from the beneficiary. H.R. 3573 limits Medicare's payment by requiring providers to accept the payment limit as the total charge for the service. Thus, beneficiaries are only liable for the coinsurance associated with the $50 cap on payments. This provision may limit availability and thus we estimate that utilization will increase to only 30 percent under H.R. 3573.

The magnitude of the increase in utilization of annual mammography with Medicare coverage is uncertain. It is likely that the increase will be smaller in the first year with a greater increase in successive years. Therefore, from our current utilization rate of 12 percent, we have assumed an increase of around 10 to 15 percentage points in the first year of coverage and around 20 to 25 percentage points in the following years. Thus, we project that approximately 25 percent of those eligible in the first year will have an annual screen with 35 percent utilization in the following years, with the exception of H.R. 3573 where we estimate 20 percent utilization in the first year and 30 percent utilization in the following years.

Because of the uncertainty about future utilization rates, we calculate the projected outlays for alternative utilization rates of 15 percent and 50 percent for H.R. 3573. With 15 percent utilization, the 5-year total outlays would be $415 million; with 50 percent utilization the 5-year total outlays are $1,425 million. These figures compare with our current projection of 30 percent average utilization and $82 million in 5-year total outlays.

## Eligibility

For the purpose of estimating the different eligibility requirements of the proposed bills, we have broken down the Medicare eligible population of women into various age groups, as shown in Table 3.

TABLE 3. FEMALE ENROLLEES IN MEDICARE

(by fiscal years, in millions)

| | 1988 | 1989 | 1990 | 1991 | 1992 |
|---|---|---|---|---|---|
| Female Enrollees | | | | | |
| 65 and over 1/ | 17.48 | 17.82 | 18.16 | 18.51 | 18.87 |
| 50 - 65 | .78 | .79 | .81 | .82 | .84 |
| 40 - 49 | .15 | .15 | .16 | .16 | .16 |
| 35 - 39 | .06 | .06 | .06 | .06 | .07 |
| Total Female Enrollees | 18.47 | 18.82 | 19.19 | 19.55 | 19.94 |

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1/ Since mammogram screening is primarily an outpatient service, we assume that few, if any, nursing home patients would utilize it. There are only one million females in nursing homes, so it is unlikely that their lack of usage will substantially change the cost estimates.

All of the bills provide coverage for Medicare beneficiaries age 65 and older. H.R. 3573 includes annual screens for all women age 50 and over, limited screens for women between the ages of 40 to 49, and baseline screening (one screen) for women between 35 to 39 years of age. H.R. 2482 and H.R. 540 cover all Medicare beneficiaries.

## Indirect Costs and Savings

Our estimates include only the direct costs to Medicare associated with coverage of annual screening mammograms. To the extent that screening exams lead to further diagnostic tests and treatment of breast cancer, the costs to Medicare will increase more than our estimates indicate. On the other hand, various studies show that the cost of treating breast cancer caught at an early stage are less than the costs of treating breast cancer caught later. While the magnitude of these two effects is very uncertain, it seems clear that in the short run, the indirect effect of Medicare coverage of screening mammograms will increase costs.

Chairman **Stark**. Mr. Coyne.

Mr. **Coyne**. I have no questions.

Chairman **Stark**. Mr. Pickle.

Mr. Anthony.

Mr. **Beryl Anthony**. Thank you, Mr. Chairman.

Tommy stated that he would support mandatory assignment at the $50 level. I didn't hear what your comment was on that, Mary Rose.

Ms. **Oakar**. It depends on who the assignment was. I have to say that I have a certain bias against some of the physicians who only prescribe radical mastectomy for women. I would hope that if you did have assignments, that you would have enlightened doctors who know when to do more extensive surgery, when to perform lumpectomies, when to use other forms of treatment. Believe me, I think, as a student of this issue, that there are a lot of enlightened doctors, and there are an awful lot of unenlightened doctors, and that is one of the reasons women are so afraid of the disease, because of the unnecessary surgery.

Mr. **Beryl Anthony**. I guess what disturbs me is that we will all be concerned about the cost.

Ms. **Oakar**. Sure.

Mr. **Beryl Anthony**. We just finished passing it in this committee and the Congress and the Senate have now passed it, and I assume we will be working on a compromise on catastrophic illness. Yet, in the face of the cost deficit, this committee had to cut $1.3 billion out of the basic Medicare program. I assume that the economic summit that is going on right now may have an even further effect on this.

Mandatory assignment is a controversial concept. It is a controversial issue in the medical profession, and I guess what I am trying to get clearly understood from two supporters of this particular piece of legislation is if we extend coverage under Medicare for a preventive program, would it be fair to lock in mandatory assignment for that preventive program only, or would it be appropriate now for us to step forward and have mandatory assignment locked in for all services covered under Medicare? Would either one of you care to comment on that?

Ms. **Oakar**. Then what you are doing is making it pretty much of an HMO program, which I think has some merit, depending on how you get, and that is difficult, but with mammography, I could honestly see mandatory assignment, but I am not sure I would feel that way about breast surgeons, only because they don't all think the same way about this issue, but it is something. If you put a cap on it, to me that amounts to the same thing, and then people could still have a certain degree of option.

Mr. **Beryl Anthony**. If you put a cap on it and say that that is all the doctors can charge, period, then you have done exactly what the free enterprise system says the Government should not do, and that is move toward Government-mandated socialized medicine. I just wonder how you justify putting a cap or mandatory assignment in one section of Medicare reimbursement, but not on another section.

I know my friend—I am speaking to the choir over here with my friend from Boston. It finally caught his attention. It is something that he offers at every subcommittee markup. Probably one of these days he will be successful in getting the votes, but it doesn't seem to be there now. You can tell me how controversial it is every time you offered that amendment. Am I making sense?

Ms. Oakar. Yes.

Mr. Beryl Anthony. In terms of what you are saying?

Ms. Oakar. Sure.

Mr. Beryl Anthony. It just seems to me that that could be a fatal flaw in the policy of trying to figure out how to pay for it and how to hold the costs down.

I yield my time.

If you have a followup comment, Tommy, that you would like to make, I will yield, but I just think that this is something that we have got to really keep in mind in terms of the overall policies and politics of other portions of the Medicare system at a time when we are expending benefits and cutting the basic benefit in the very same year.

Mr. Robinson. Beryl, if I could follow up, I know it is controversial, but I am prepared to bite the political bullet in order to save thousands of lives. I think if we are going to try and expand programs, we are going to be forced to put a cap on the cost of those programs. I know it is controversial and I probably side with the AMA more than any other person around, but this is a very serious matter.

I think we have got to set aside the politics of it and move forward and try to encourage as many females in our society to take advantage of this as we possibly can at an affordable price.

Mr. Beryl Anthony. Thank you.

Chairman Stark. Mr. Gregg.

Mr. Gregg. I was just wondering about two things. One, as I understand it, everybody would have the right to this mammogram, is that correct?

Mr. Robinson. Yes.

Mr. Gregg. And it would be paid for by the hospital insurance trust fund out of Medicare payment, correct?

Ms. Oakar. Right.

Mr. Gregg. I guess my concern, and one of my concerns about the whole Medicare system, is where we are dealing with a pie that is finite, which is the Medicare and hospital trust fund, and we are benefiting a lot of people who have the wherewithal to pay for things themselves, in this instance you would be benefiting a tremendous number of people, I would suspect. The majority of people who would get this benefit could afford it, to pay for it themselves.

I am wondering if there isn't some structure that could be put in place which would allow those people who are wealthy enough to pay for this to pay for it, and then those people who aren't wealthy enough to pay for it, the hospital trust fund would pay for it. Have you given any thought to that?

Mr. Robinson. I think that is one option that we could take a look at, similar to the means testing of several other programs that we are beginning to see evolve out of this body. I don't have a problem with structuring a bill that is designed to help those who need help, and to allow the others that can afford it to pay for the test.

**Mr. Gregg.** Means testing, if the word has a negative connotation, I sort of like the word "rich" test.

**Chairman Stark.** If the gentleman will yield, I am not sure this solves the problem, but as I understand it, a couple of the bills might. This benefit would be under part B of the Medicare program, so that the 75 percent of part B that is paid by general revenue really comes out of the income tax, which is progressive. I am not sure that is a good policy for all future expansion of Medicare services, but in this case it would probably be good.

**Mr. Gregg.** Then you end up with that problem which Mr. Moody has addressed so often and so well, which is an inter-generational transfer.

**Chairman Stark.** It doesn't necessarily solve the problem. Under one bill the benefit would be under part B, and therefore a major part of it would be paid by general revenues.

**Mr. Gregg.** Can I ask another question on another issue. It seems to me one problem that you are going to have with this is getting women to participate in it, in the program. As I understand it, the cost estimates presumed that less than 50 percent of the women will actually take advantage of the service.

Is there some way to tie this service, because of its importance, to renewal, to annual renewal of the Medicare system, the premium, so that a person has to have this check-up before they can get their insurance confirmed?

**Ms. Oakar.** Let me tell you, I think the idea of having a check——

**Mr. Gregg.** Not mandatory payments, just mandatory checkups.

**Chairman Stark.** Can you imagine the headline in the Manchester Guardian?

**Mr. Gregg.** We don't mind Manchester Guardian. How do you get people into the system?

**Ms. Oakar.** Can I say, Congressman, the truth of it is lots of women would like to have a mammogram, but can't afford it. You really have to start with that premise. A good portion of women would like to receive mammograms but I don't know if I agree with the estimates. I don't know how they arrived at them. The fact is that older women for the most part can't afford a mammogram, and the mammography rates are fairly low because we don't have a lot of people taking advantage of it.

I think we have to do a better job in education, and I think we have to make it affordable. We have to make it part of the prevention of the catastrophic problem, so that we can deal with this whole issue in a long-term manner.

**Mr. Gregg.** I don't argue that there are a number of seniors who can't afford it, and that we should address their concerns. I would debate the issue of the majority. I think you will find that seniors as an income class are better off than any other class in the country today.

**Ms. Oakar.** What? I'm sorry?

**Mr. Gregg.** In age group function, the seniors in this country are better off financially than any other age group in the country.

**Ms. Oakar.** I would surely debate that, but you are on the committee and I want you to vote for the Congressman's bill.

Mr. **Gregg**. But I would like to pursue if you have any ideas on the issue of rich testing, to see if there is a way that you could do it other than transfer it inter-generationally, if you have any thoughts on that?

Ms. **Oakar**. I do think it is worth pursuing, and there is a need for education. The fact is, though, some say that until you are 35, depending on your situation, and really past 40, that is when you really need to have mammograms performed more often than not. So it is more or less the older woman that you are really targeting in this particular case.

This is not true, obviously, with other kinds of screening, like Pap smears, colon screening and that sort of thing.

Chairman **Stark**. Mr. Pickle.

Mr. **Pickle**. Mr. Chairman, the only question I want to ask is one that pertains to mandatory examination, mandatory coverage. Does the bill that you are interested in require the mandatory assignment approach?

Ms. **Oakar**. Mine does not, but I don't have a problem with mandatory assignment for mammograms. I would have if it related to the surgery, only because, with respect to breast cancer, there is an awful lot of unnecessary surgery performed.

You can show studies that give the same statistical data on women who have lumpectomies versus radical, where they take everything out and they have swollen arms for the rest of their lives and that sort of thing.

Mr. **Pickle**. The chairman's bill has a fee of $50? Does that seem reasonable to you?

Ms. **Oakar**. Yes.

Mr. **Robinson**. It seems reasonable to me also.

Mr. **Pickle**. To both of you?

Ms. **Oakar**. Yes.

Mr. **Robinson**. Yes.

Mr. **Pickle**. Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. Thank you, Mr. Chairman.

I would like to add my word of applause for your holding this hearing, and for our two distinguished colleagues' activity in this effort. I hadn't really focused on this issue until I saw the hearing documents, and my reaction was one of amazement that we are so far behind on this.

When the First Lady benefited from a mammography test, and they were able to really carry out preventive medicine, I think all of us breathed a real sigh of relief and were thankful that they were able to detect the malignancy at a stage where, as you said so eloquently, there is 95 to 100 percent certainty of cure.

I would assume that the First Lady has the same medical benefits that we do in Congress, and she was entitled to that test free of charge, and that it is part of an annual checkup or maybe even a semiannual checkup that is paid for.

The successful testing in that case raises the question whether everybody in this country should not be on an equal footing, and I would think she would be the first to say yes. I don't think there is anything intergenerational about people being able to receive this kind of screening.

I am sorry in a way your testimony won't be at the same time as HCFA's, because I think it would have been interesting for the three of you, the two of you and Dr. Anthony to testify on the same panel. He seems to ascribe three reasons for not—I am not sure what the conclusion is—maybe not acting at this time.

Let me just ask you to comment on one of them. You have already, but zero in on this. On page 3 of his testimony, he says:

> Past studies on the effectiveness of preventive services have not addressed the potential benefits such care would have on the health status and well-being of the elderly.

I take it from your testimony that whatever the arguments may be about other preventive services, you just feel, both of you, that when it comes to mammography, there is really no question about the potential benefits such a service would have on the health status and well-being of the elderly.

Ms. **Oakar**. To me the statement is ironic. I didn't read his testimony yet. I know he is here in obvious sincerity. But I just can't imagine why that wouldn't be helpful for an older person to get a mammogram. I guess I am missing something.

I mean, it would enhance the well-being and quality of life for older people and, indeed, for younger people, because it is a family issue.

Mr. **Levin**. Do you have anything further——

Mr. **Robinson**. As I stated earlier, prevention of disease is one area where Medicare coverage is lacking. They have a mindset that is not conducive to preventing disease. They are more concerned about how much money they are going to dole out after one is in the terminal phase.

Mr. **Levin**. I am further mystified by that. In the previous paragraph, it states:

> Studies on mammography have generally found this screening procedure to be effective in detecting breast cancer early, thus improving the chances for a longer life.

I think your testimony has highlighted the need for us to move on this. I thank you very much.

Chairman **Stark**. Mrs. Kennelly. I would like to welcome Mrs. Kennelly to our subcommittee, who, although most of you don't know, isn't a member of the subcommittee but she is so active with us. Thank you.

Mrs. **Kennelly**. Thank you for letting me participate in the subcommittee hearing, Mr. Stark. Congresswoman Oakar, on the second page of testimony, I would just like a little clarification. You say that a physician must discuss options women have in the treatment of breast cancer, just as Nancy Reagan had options. She had the option to make a choice, and she apparently chose the more conservative method of treatment. But the important point is she chose a treatment.

It is my understanding that we are talking about options or discussing what options you have. And there is the thought that some hospitals and some physicians do the testing, the biopsy, and the patient wakes up from——

Ms. **Oakar**. That is the old way.

Mrs. **Kennelly**. Yes, and discusses it. Yet, you say Mrs. Reagan chose the more conservative method of treatment. Now, I have heard some comments about Mrs. Reagan's treatment. Since she had the mammography early and detected the cancer, and it was a very small lesion, she could have chosen to have a much less radical form of treatment. She could have just not had the breast removed.

I want to make sure we know that she didn't choose a conservative method; in some people's mind, she chose a more radical route. Of course, it was her choice.

Like all of you and all of us, we have been concerned about Mrs. Reagan. I guess sometimes the only time we talk about it is when women like Mrs. Reagan get breast cancer. I think we should highlight the fact that by having a mammography, you can find the cancer so early, and that you just have to have the preventive treatment and not lose the breast.

I have heard comments, because she did choose the method she chose, of women saying, "Well, I am going to wait a couple years and keep my breast a couple more years and not have the radical treatment."

Ms. **Oakar**. You know, words can be misleading. For example, I guess perhaps the choice of the word "conservative" is misleading. However, I don't want to use the word "radical" either. It is difficult to judge when you are not involved in all the ideas, but it appears that she could have had a lumpectomy instead.

Mrs. **Kennelly**. That is right. That is what I want to clarify.

Ms. **Oakar**. There have been studies to show which treatments are best for each condition. There has also been a study of women receiving lumpectomies versus women who had more radical surgery, and the results were the same in terms of mortality rate.

And so, the old days when they used to knock women out, and they didn't know what they were going to do to them, are over, hopefully, but I mean they should be over but they are not over. That is why I have a feeling the doctor would have to say, listen, there are a couple ways we might be able to treat this. Here is what I would do, but here are some other ideas.

That is why I feel informed consent is very important, because there is some unnecessary surgery going on, not only for women, but for men with certain diseases. So, we ought to really understand that. The way Nancy chose to be treated may not be the way that some other women——

Mrs. **Kennelly**. She knew exactly what she wanted, she went to her process in a very fine form. However, many women might not have chosen that, and I want to highlight the fact by having this treatment, that you can have early preventive care and not lose your breast, and that is the whole point of having the treatment.

Ms. **Oakar**. Exactly. I am so glad you stated that.

Mrs. **Kennelly**. Thank you for your excellent work.

Chairman **Stark**. If the witnesses will bear with me, I would like to recognize Mr. Daub for a moment, and then recess for the vote.

Mr. **Daub**. I commend each of you for being here and helping us with a very special subject. I am very pleased with the chairman's leadership on this particular subject. I recall his interest in a bill that I authored with respect to the cost under medicare of therapeutic shoes for people who have diabetes. The action when costed out by making the change for reimbursement for services actually saved money, and it really is important to look at that here in the Ways and Means Committee. But, more importantly, this bill will save lives.

Your testimony is going to help urge us to action where we might study the matter for a little longer. Thank you very much for being here and for your eloquent testimony before the committee.

Chairman STARK. I want to thank both of the witnesses for their interest in this area, and in their work, in keeping our feet to the fire, and invite you both to come back. There are many areas in which we certainly don't have the last answer, and too often we wait for some major public occurrence that pushes us to acknowledge a problem.

Your keeping after us is appreciated, and I want to thank both of you for taking the time to be with us today. We will recess for 5 minutes for the vote. Then our next witness will be Mr. Ross Anthony, the Associate Administrator for Policy at HCFA.

[Recess.]

Chairman STARK. The committee will resume.

Welcome to the committee Dr. Ross Anthony, Associate Administrator for Policy, accompanied by Kathleen Buto, Acting Director of the Bureau of Eligibility Reimbursement and Coverage.

Dr. Anthony, we have, I believe, your prepared statement, and without objection, it will appear in the record in its entirety. If you would like to summarize it for us or expand on it in any way you are comfortable, you may proceed.

## STATEMENT OF C. ROSS ANTHONY, PH.D., ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY KATHY BUTO, ACTING DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT, AND COVERAGE

Mr. Ross ANTHONY. I am Dr. Ross Anthony, Associate Administrator of the Health Care Financing Administration. With me is Kathy Buto, Acting Director of the Bureau of Eligibility, Reimbursement, and Coverage. I am here today to discuss Medicare coverage for mammograms and touch more generally on Medicare's role in prevention.

Medicare pays for mammograms as part of the diagnosis and treatment of breast cancer. In order to qualify for medicare payment, the patient must meet one of three criteria: have symptoms of breast cancer, have a history of breast cancer, or, if the patient is asymptomatic, the physician may judge the test is needed based on medical factors deemed significant.

In 1985, Medicare reasonable charges totaled $37 million for almost 900,000 mammograms. As has been indicated already, Medicare is not authorized to pay for mammograms as part of routine medical care. This is because the Medicare benefit package was patterned after existing health care insurance in the mid-1960s. Like the private insurance structure, the original Medicare legislation covered benefits only for diagnosis and treatment of illness or injury, and did not cover routine preventive care.

Even today, few insurers provide full coverage and reimbursement for preventive services. It is important to realize that what HCFA implements today is, in fact, what was in statute.

There are, however, three exceptions to the illness or injury provisions in Medicare. In recent years, Congress has expressly authorized Medicare payment for two preventive services. In 1980, payment for pneumococcal vaccine was authorized, and in 1984, payment for hepatitis B vaccine was approved for high and intermediate-risk individuals.

There is a third method by which preventive services are paid for—through HMOs.

Beginning in 1985, Medicare beneficiaries who enroll in HMOs can receive physical examinations and other preventive services. This is because HMOs as a condition of Federal qualification are required to provide preventive services for non-Medicare enrollees, and many plans extend these services to Medicare beneficiaries as an extra benefit.

The Medicare program does not incur any additional costs for these extra services. Beneficiaries also do not incur additional costs for these services other than nominal copays. An ongoing survey of our current risk contractors indicates that an overwhelming majority of enrolled beneficiaries are covered for routine mammograms.

The administration strongly believes Medicare beneficiaries should have a choice and selection of appropriate health care to meet their individual needs. One option we support strongly is managed health care, such as that provided by HMOs.

Over half of our current beneficiaries live in areas where Medicare has signed a contract with an HMO, and by selecting an HMO, most beneficiaries can obtain preventive health care if they feel that option is important to them. Otherwise, a beneficiary is free to select care paid for on a fee-for-service basis.

Let me turn to the sentence quoted earlier. Studies of mammography have found this screening procedure to be effective in detecting breast cancer earlier, thus increasing chances for a longer life.

So, the medical evidence on mammograms I think is quite clear. There are numerous studies, and they all indicate this is a medically effective and appropriate procedure. Despite this advantage, utilization has often been low, even when reimbursement was available, because of lack of awareness of the procedure, concern about the potential risk of radiation, discomfort, or fear of adverse diagnosis.

Past studies of the effectiveness of various preventive services have not addressed potential benefits such care would have on the health status and well-being of the elderly. For this reason, we have several demonstrations under way which will examine how specific preventive services can help reduce severe illness in the elderly.

Two demonstrations under way to assess the effect preventive benefits have on Medicare costs and patients' quality of life, are being conducted by Blue Cross-Blue Shield of Massachusetts and the University of North Carolina. These projects are examining the effects of different types of preventive strategies such as an annual health risk assessment and information on smoking and diet.

Five other congressionally mandated demonstrations will begin sometime next year and will examine prevention strategies, including routine tests, immunizations and instructions in healthy living.

At least one project by statutory direction will include cancer screening, including routine mammograms. Upon completion, these projects will be evaluated to determine the short- and long-term cost benefits of providing various preventive health services to the elderly.

In conclusion, Medicare pays for mammograms when used to diagnose and treat breast cancer as part of the routine preventive care generally provided to beneficiaries enrolled in HMOs, although Medicare does not cover routine preventive mammograms.

In addition, we are actively exploring the effects specific preventive services may have on the health conditions and health costs of the elderly. The results of these studies will provide us with better information to determine how Medicare financing of preventive services, including coverage of mammograms, can contribute to meeting the health care needs of the elderly.

I would be glad to answer any questions that you have.

[The statement follows:]

## Statement of C. Ross Anthony, Ph.D., Associate Administrator for Program Development, Health Care Financing Administration

I am C. Ross Anthony, Ph.D., Associate Administrator for Program Development of the Health Care Financing Administration. With me today is Kathy Buto, Acting Director of the Bureau of Eligibility, Reimbursement and Coverage. I am here to discuss Medicare coverage of mammograms and, more generally, Medicare's role in prevention.

### BACKGROUND

Medicare pays for mammograms as part of the diagnosis and treatment of breast cancer. In order to qualify for Medicare payment, the patient must have symptoms of breast cancer; have a history of breast cancer; or if the patient is asymptomatic, the physician may judge that the test is needed based on medical factors deemed significant. In 1985, Medicare reasonable charges totaled $37 million for almost 900,000 mammograms.

However, Medicare is not authorized to pay for mammograms as part of routine medical care. This is because the Medicare benefit package, when enacted, was patterned after existing health care insurance in the mid-1960's. Like the private insurance structure, the original Medicare legislation covered benefits only for the diagnosis and treatment of illness or injury and did not cover routine preventive care. Even today, few insurers provide full coverage and reimbursement for preventive services.

### EXCEPTIONS

There are three exceptions to the illness or injury provisions of Medicare. In recent years, Congress has expressly authorized Medicare payment for two preventive services. In 1980, payment for pneumococcal vaccine was authorized and in 1984 payment for hepatitis B vaccine was approved for high and intermediate risk individuals.

In addition, beginning in 1985, Medicare beneficiaries who enroll in HMOs can receive physical examinations and other preventive services. This is because HMOs, as a condition of Federal qualification, are required to provide preventive services for non-Medicare enrollees, and many plans extend these services to Medicare beneficiaries as an extra benefit. The Medicare program does not incur any additional costs for these extra services. The beneficiaries also do not incur additional costs for these services other than nominal copayments. An ongoing survey of our current risk-contractors indicate that an overwhelming majority of enrolled beneficiaries are covered for routine mammograms.

The administration strongly believes that Medicare beneficiaries should have a choice in the selection of appropriate health care to meet their individual needs. One option that we strongly support is managed health care such as that provided by HMOs. About half of our current beneficiaries live in areas where Medicare has signed a contract with an HMO. By selecting an HMO, most beneficiaries can obtain preventive health care, if they feel that option is important for them. Otherwise, the beneficiary is free to select fee-for-service care.

### THE NEED FOR RESEARCH AND DEMONSTRATIONS

Studies on mammography have generally found this screening procedure to be effective in detecting breast cancer early, thus improving the chances for a longer life. Despite this advantage, utilization has often been low even when reimbursement was available because of lack of awareness of the procedure, concern about the potential risk of radiation, the discomfort of the test, or fear of an adverse diagnosis.

Past studies on the effectiveness of preventive services have not addressed the potential benefits such care would have on the health status and well-being of the elderly. For this reason, we have several demonstrations underway which will examine how specific preventive services can help reduce severe illness in the elderly.

Two demonstrations are underway to assess the effect prevention benefits have on Medicare costs and patients' quality of life. Conducted by Blue Cross/Blue Shield of Massachusetts and the University of North Carolina, these projects are examining the effects of different types of prevention strategies, such as annual health risk assessments and information on smoking and diet.

Five other congressionally mandated demonstrations will begin sometime next year and will examine prevention strategies including routine tests, immunizations, and instructions in healthy living. At least one project will include cancer screening, including routine mammograms.

Upon completion, these projects will be evaluated to determine the short- and long-term costs and benefits of providing various preventive health services to the elderly.

### CONCLUSION

In conclusion, Medicare pays for mammograms when used to diagnose and treat breast cancer and as part of the routine preventive care generally provided to beneficiaries who enroll in HMOs.

In addition, we are actively exploring the effects specific prevention services may have on the health conditions and health costs of the elderly. The results of these studies will provide us with better information to determine how Medicare's financing of preventive services, including coverage of mammograms, can best contribute to meeting the health care needs of the elderly.

I will be happy to answer any questions that you may have.

Chairman STARK. Thank you.

I am not quite sure I understand the history of this, but are you really saying that if the test is a diagnostic or a curative, then Medicare will pay?

Mr. ROSS ANTHONY. That is correct.

Chairman STARK. But where it is preventive, you won't pay unless Congress passes a rule. What is the reason or why does HCFA say you can't have preventive tests? Let's leave the HMO thing aside.

What is the history behind that?

Mr. ROSS ANTHONY. The history is really quite clear. HCFA, as the Health Care Financing Administration, administers the Medicare program. The original statute that enacted Medicare into law provided for coverage of acute illness and did not provide for payment of preventive care.

We have implemented that statute and continue to do so. So, really, the origin of the present coverage decisions on this and other preventive services goes back to the original statute.

Chairman **Stark**. And you don't differentiate between diagnostic and preventive? Am I missing something in medical parlance that says we ought not do a lot more diagnostic testing?

I assume it is OK if I call it diagnostic.

Mr. Ross **Anthony**. My doctorate is economics, so I won't claim to be a medical expert here. But, as a matter of fact, in this particular area, we go about as far as is possible to allow for coverage of this service while still meeting the statute.

As a matter of fact, one of the sentences I read earlier in my testimony is that when the patient is asymptomatic, that is, there is no clear indication of the disease, we in fact will cover that mammogram test if in a physician's analysis and judgment of the factors, he finds that it is indicated.

That is about as far as I think you can go without saying that routine tests will be covered.

Chairman **Stark**. The fact is that the patient would have to be in the hospital for some other reason.

What you just can't do is have a woman walk in the emergency room in a hospital and say, I would like a mammogram.

Mr. Ross **Anthony**. That is correct.

Chairman **Stark**. That is where the line gets drawn.

Mr. Ross **Anthony**. There is certainly a gray area here. The clearcut case which we don't cover is the routine annual physical that routinely provides a mammogram as a preventive service.

Chairman **Stark**. Under your HMO provisions, regulations, do you mandate any level of preventive or routine care? Does the HMO have to see the patient once a year or can they just sign them up, give them their free glasses, pat them on the back and not see them for the next year?

Mr. Ross **Anthony**. We don't mandate they have those types of preventive annual checkups, but it is our understanding, in fact, most of them do.

Chairman **Stark**. Don't most of the HMOs do some kind of medical questionnaire to screen for existing medical conditions?

Mr. Ross **Anthony**. I believe that is true, yes.

Chairman **Stark**. We have had a request, and in the absence of Congressman Russo, I thought I would just ask—we have requested several demonstrations concerning preventive services, and I wonder if you know whether any of those are rising close to the top of the heap, or when we might start to get some results of any of these demonstrations, particularly as they would bring evidence to bear on this issue?

Mr. Ross **Anthony**. I would be glad to send, for the record, a complete description of where we stand on all of the demonstrations but let me just summarize very quickly. I think generally we are on schedule, as you mentioned, unlike some other areas.

We have two demonstrations underway now, Blue Cross-Blue Shield of Massachusetts and the University of North Carolina, Chapel Hill. Under COBRA, there were a number of other demonstrations mandated. We have received at this point 11 applications, I understand, for the five demonstrations mandated, and decisions as to who will be receiving those contracts will be forthcoming. We expect those demonstrations to be underway sometime in the next 6 months or so.

I guess I should point out the statute required that one of those would investigate cancer screening, in particular, mammograms. Of the 11 applications, I understand four do include mammograms within their applications.

That is not to say that all four will be the approved demonstrations, but there are a number that we will consider.

Chairman **Stark**. Do you know how many of those applications were from the Oakland Bay Area of northern California?

Mr. Ross **Anthony**. I honestly don't know. I will have to investigate that.

[The following was subsequently received:]

### Prevention Demonstrations

HCFA published a special solicitation in the *Federal Register* on May 29, 1987 for these projects with a closing date of August 27, 1987. Applications were received from 11 schools of public health. None were specifically from the Oakland Bay Area. There were three, however, from California Schools of Public Health including UCLA, Loma Linda, and San Diego State.

The expert review panel met on November 9 and 10, and we plan to fund 5 projects by mid-1988. At least one of these projects will include a preventive breast screen as part of the preventive service package.

Chairman **Stark**. Mr. Donnelly.

Mr. **Donnelly**. No questions.

Chairman **Stark**. Mr. Coyne?

Mr. **Coyne**. Thank you, Mr. Chairman.

I would like to follow up on the chairman's line of inquiry relative to your interpretation of the present law; namely that of not including payment for these tests. It is my understanding, then, if Congress were to take the leadership role which HCFA does not see fit to do at this present time, you should have no objection to going ahead with implementing the law?

Mr. Ross **Anthony**. We always implement the law. But let me say, we look at the law and try to do what is right. I think it is important to recognize here a couple of things.

If I were to go back to 1965 and have the opportunity to rewrite the Medicare program, I would join the chairman in changing many aspects of it. I spent a good deal of my life overseas promoting preventive health care, and this is one area where I feel the medical evidence is clear-cut.

Mammograms are an effective test which, if you asked me if my wife should receive the test, my mother, et cetera, I would without reservation say yes. I think you have to think about how it relates to a lot of other things. Even where we have clear-cut benefits that medical evidence supports, you have to ask the cost question, which again Mr. Stark alluded to.

If we are to include this as a benefit, then you have to ask where, in fact, the funds are going to come from to pay for this. And that, to me, is the question that you and the Congress have to face, because you know we all have tremendous problems in facing a very large deficit, and where you try to evaluate what the private sector should pay or not pay for, those are tough issues indeed that you wrestle with every day.

Mammograms are one more example of a clear-cut service that is medically called for that fits into that category.

Mr. **Coyne**. Thank you very much.

Chairman **Stark**. Mr. Levin?

Mr. **Levin**. Let me follow that up, because that isn't really what the testimony says, as I read it. You say you reviewed the history of the act, and then you said at the bottom of page 2 that the administration strongly believed medicare beneficiaries should have a choice in the selection of appropriated health care to meet their individual needs, and then you talk about HMOs.

Now, what does that have to do with this issue?

Mr. Ross **Anthony**. It has to do with this issue because one clear option where beneficiaries, even today, can choose to have mammograms covered as a routine preventive service is through the HMO program. We did a quick survey to try to determine for the purpose of this hearing what percentage of HMO Medicare risk contracts cover routine mammograms, which we would not cover under Medicare fee-for-service. It appears approximately three-fourths of the HMO's, in fact, cover routine mammograms.

Mr. **Levin**. I understand that. Let me break in and say, you are speaking for the administration now——

Mr. Ross **Anthony**. That is correct.

Mr. **Levin**. Is it HCFA's position that the Congress' position should be to women, if you want mammography, you must join an HMO?

Mr. Ross **Anthony**. Our position is that if it is important to you, you have an option available to you today, even if Congress does not act. If you don't change the law, we can't cover routine mammography.

If you choose not to do that, then even today, over 50 percent of Medicare beneficiaries live in areas where they have the option to join a prepaid health plan if they so choose. If they wish that, this is one avenue to being covered for mammograms that is open to them even today.

Mr. **Levin**. I understand that, and I very much favor the tilt toward HMOs. But is it your position that it is sound public policy to tell people, if you want coverage for mammography, join an HMO?

Mr. Ross **Anthony**. I think whether you join an HMO or not shouldn't hinge just upon whether or not that HMO offers you mammogram services. That should be one thing that each individual might wish to consider, but obviously all individuals are different, and we believe strongly they ought to have the choice available to them.

But we leave the choice in terms of evaluating that service package to the individual.

Mr. **Levin**. Is it sound public policy to condition reimbursement for mammography on a person joining an HMO, yes or no?

Mr. Ross **Anthony**. I am sorry, I was——

Mr. **Levin**. Is it sound public policy for Congress and the administration to condition reimbursement or coverage for mammography on someone joining an HMO?

Ms. **Buto**. I just wanted to elaborate before Ross answers that question. That question could be broadened to include hypertension screening, blood tests for colorectal cancer, Pap smears, a number of very effective screening procedures that Medicare also does not cover.

I think you have to ask the question for the whole Medicare population, not just for women—whether these kinds of screening tests are more important to you than having a choice of your own fee-for-service physician?

Beneficiaries clearly have that choice, and we feel that they are increasingly making the choice to have that broader range of services. But at the moment, that is the choice.

Mr. LEVIN. I know, but you can't conduct the issue by expanding it. The question is: Is it sound public policy to tell people that if they want this kind of screening, join an HMO? If you don't, you don't have it covered? You know, you, like Members of Congress, eventually have to push a green button or a red button.

Is that sound public policy?

Mr. ROSS ANTHONY. Unfortunately, I don't have the option you have, which is you can change the law. If somebody comes to me and asks me, should we consider mammograms within the context of HMOs and not ask the larger public policy questions, the answer is we should consider the larger public policy as you are doing here today.

If someone comes to me and asks me, this is really important to me, how can I get this covered under Medicare? I have only one option, and that is to tell them under HMOs they have this option, but under the regular Medicare fee-for-service program, we do not cover preventive mammograms.

Mr. LEVIN. If you are advising an individual person, you say you can receive coverage by joining an HMO. But the way you write it—you are asked to consider this issue: Should we bring mammography within the Medicare system, you are not advising an individual patient or person as to whether they should join an HMO or not, so you in a sense confuse the issue by answering the question we put to you about expansion of Medicare by saying what might be a good choice by an individual.

And as far as I favor a tilt toward HMOs, it is going quite beyond a tilt to have absolute conditionality. I take it you don't favor absolute conditionality.

You then go on to say utilization has been low, on page 3, when reimbursement was available. Is that an argument against our changing reimbursement procedures?

Mr. ROSS ANTHONY. No, it is simply a fact that I think you need to consider, and you will hear from a number of other witnesses whose cost estimates are very dependent on what that figure is. Right now, I think it is somewhere in the 16- to 20-percent range. I think some of the estimates, as I quickly looked over the sheets here, assumed a 30-percent utilization.

It is something that you need to think about, both in terms of whether you cover the service, or whether education is something that might be important to let women be aware of the benefits of this program.

It was not meant to connote anything more than just a fact.

Mr. LEVIN. That is not an argument against coverage.

Mr. ROSS ANTHONY. No.

Mr. LEVIN. Now, in the next paragraph of that sentence I quoted earlier, you talk about past studies and the effectiveness of preventive services, et cetera. You acknowledge in this case the potential benefits such care would have on the health status and well-being of the elderly is essentially proven.

Mr. Ross ANTHONY. Again, I am not a physician, but as I read the evidence and the studies and the briefings I have received, the answer from my perspective is yes.

Mr. LEVIN. So, in a word, it seems to me that you get down to an issue of the cost. Is HCFA for or against this? I mean, in your testimony—I mean that respectfully. Are you for or against it?

Mr. Ross ANTHONY. Let me speak personally. If I got to go back to 1965 and redesign the Medicare program, then, in fact, I would cover this service. I don't have that option, as you in a sense don't have that option.

It is clearly a beneficial thing that offers benefit to women. The real issue, however, is we are not in a vacuum today, we have a terrible budget deficit problem that you wrestle with every day.

And if you were to decide to cover this, you have to find some way to pay for it. And I think that truly is the public policy question we have today. It is important that when you start talking about cost, that you not just look straight at the cost of what it might be to provide the coverage to one individual.

There is the physician cost, there are the secondary costs that might also be indicated, and you need to, I think, enter into any kind of discussion in a clear-minded way.

Mr. LEVIN. I close by saying I agree with that completely. It just seems to me, if I might say so, that when there is a bill that proposes coverage and the Executive is asked for its reaction, it should get to the point.

Your testimony doesn't focus on the issue of costs. You throw up the history of the act; that is relevant. You talk about HMOs, but you don't urge we make joining it a condition of coverage.

You talk about the utilization factor, but that is not relevant, except we need to educate people more, which would cost more. And then you talk about past studies on the effectiveness of preventive services, even though your position is there is no issue here on this test.

And then you close by saying the act is probably out of kilter, not only as to this test, but other preventive services, and then you say a shift towards prevention is going to add to the cost in the Congress and the administration, which is really the nub of this had-better-think-about-cost.

The reason I think it is important, because when you obscure need rather than talking about cost, we miseducated the public as to what the issue is. I feel that deeply, that here there is a clear—and I confess my ignorance, I hadn't focused on this, and I regret it. It took an illness of the First Lady to bring home to a lot of people that here is a service that is not covered by people in her age bracket that can be dramatically affected by a simple periodic check.

That is the long and the short of it. And we don't need to obscure—I am all in favor of studies, but not when there is no need for it. And I think it helps for you to come before this committee and say, look, there is a need here, the statute is out of kilter, the test works, we can educate people to take it; the more we educate the more it will cost; and lady and gentlemen of the subcommittee, the real issue is the cost and the precedent it sets in terms of other preventive services, then the public knows what the issue is.

And so, I just think this is a most useful hearing, and I think this colloquy between you and all of us is useful, also.

Mr. Ross **Anthony**. Let me just simply say, I hope I was clear on most of this. We don't have as much evidence on cost as I would like in the few days we had to research some of this. You will hear from OTA and some other people doing some of those studies.

I do not have the benefit of their report today. I was able to glance very quickly at their testimony. So we look forward to examining the additional work that they and others are doing now, and will continue to examine the problem.

Ms. **Buto**. I just had one comment, Mr. Levin, on your point. The cost question isn't simply a question of total aggregate costs. One has to consider where the costs are now being picked up for those mammograms currently being performed, and that is an issue that involves Medicaid.

We know a number of States cover routine screening in their Medicaid programs for poor women. In some cases private payers are also involved, although I think numerous people pointed out private payers also do not cover routine screening.

So, the question about cost is complicated by the issue of shifting costs, in a sense, from those who may be able to pay now—I think Mr. Gregg mentioned that—to other programs and other sources of payment for these kinds of tests.

Mr. **Levin**. I agree, the issue of cost is complicated. But we shouldn't use that to fuzz the issue of need.

Ms. **Buto**. There is also a need for nursing home care. There are enormous nursing home care costs associated with elderly people. It is another area we are wrestling with. It is not the only tough issue for Medicare. It is an area where we pretty much look like other insurers in this regard.

It is not like we are way out of line in the industry. The program is patterned as an insurance program for the elderly for acute care costs. That is what you are seeing today and what you are talking about is a fundamental shift in emphasis away from that and more towards preventive care if you start down this road.

It is a complicated area, one involving costs, but I think it is a fundamental policy choice that is being made.

Chairman **Stark**. Mrs. Kennelly.

Mrs. **Kennelly**. Let me take it from a little different angle. Earlier, when Congresswoman Oakar was here, she was quite specific about her feelings that women don't have mammograms because they can't afford them, and some of our colleagues brought that up and questioned that.

You mentioned that you have had studies, you have been in this field, you understand it, and you have heard a lot about it. I would be interested to know. Do you think we don't see as big a use of this as we might have? Is it because of ignorance, because you couldn't afford it, or because on a list of priorities, it doesn't rate very high?

Mr. Ross **Anthony**. I don't have a detailed list, but my own guess pretty much is it is a combination of factors. I don't believe you can probably pick any one out and say this is exclusively the reason.

Mrs. **Kennelly**. I just mean in your experience. I can tell you about my experience. I spent a lot of time with seniors, because we politicians can always find seniors to talk to. We can find nobody else. They have to put up with us, and yet, I don't remember too many seniors mentioning to me they don't have this ability to have this kind of treatment under medicare.

I remember them mentioning to me constantly they don't have long-term care, that their out-of-pocket expenses are too high. I look at that and wonder if they have so many other worries perhaps they are not worried about this. Would it be better if we were looking at education in the earlier years so it would be automatic rather than to try to educate somebody very late when they are much more worried, say about Alzheimer's, even though the facts and figures might not back that up?

I am just interested, had you found ignorance about this whole thing out there? Have you found a fear they don't want to find out that is what they might have?

Mr. Ross **Anthony**. When you say educate, do you mean ongoing literature and that type of thing? What are you talking about?

Mrs. **Kennelly**. Originally, when your Department was founded, education was very much part of it, and health education.

Mr. Ross **Anthony**. I personally am very in favor of health education. I think the more women understand the benefits of this procedure, the more they will avail themselves of those opportunities. I guess what I was getting at is medically, from what I understand, if you are below a certain age, certainly routine annual exams and mammograms are not called for simply because of radiation exposure.

I think any education that can be provided to women on an ongoing basis in most cases is certainly helpful.

Mrs. **Kennelly**. Thank you, sir.

Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Donnelly.

Mr. **Donnelly**. Doctor, I apologize, I missed your testimony, but I had an opportunity to read it, and I understand where you are coming from and what your position is today.

Let me ask a very uncomplicated question. The chairman's bill limits the reimbursement for a mammogram to $50, 20 percent of which will be paid for by the beneficiary. So, it would be a $40 cost to Medicare for each mammogram.

Do you think that is a reasonable fee?

Mr. Ross **Anthony**. I don't think that is an uncomplicated question because of the way Medicare reimburses for things. Right now, we seem to be reimbursing an average between $35 and $40 for mammograms.

On the face of it, it would not seem to be an unreasonable fee. I think you have to consider also that fees vary across the country, and these kinds of considerations need to be brought to bear when you start setting policy.

Mr. **Donnelly**. You would support a reimbursement fee based upon various cost factors between urban and rural, East and West, North and South?

Mr. Ross Anthony. We have——

Mr. Donnelly. What I am trying to get to is that you express great concern about the cost of the program, and the problem that we have with the deficit and we all agree with that. But you have to balance that off with some sort of policy statement or position on exactly what we are going to pay in reimbursement for service and, you know, I have been articulating that for years on this committee.

On the one hand, you can't say, my God, we are outraged about the cost of these programs, but on the other hand say we are not willing to stand up to the special interest constituency that benefits from the expenditure of Medicare funds.

My question is, and maybe you can't give that answer today, but I think we ought to have that answer before we move on the legislation—does HCFA believe that a $50 fee per mammogram is fair?

Mr. Ross Anthony. The fee of $40 or $50 we are talking about is not the physician fee. The physician fee would be in addition to that. So that is something——

Chairman Stark. It is an all-inclusive fee.

Ms. Buto. I don't think it includes the office visit, followup and so on. It is just for the interpretation.

Chairman Stark. If the gentleman will yield, it is for the taking and the reading.

Ms. Buto. But there is likely to be followup or an office visit associated with it. As I understand it, the estimates don't include that.

Mr. Donnelly. It is for the taking of the mammogram and the reading, which is a simple, direct procedure. Clearly, if there is a problem in the reading of the mammogram, that would be inclusive of more physician fees, hospital fees, et cetera. We are just talking about the taking and reading. Is that not a fair fee?

Do you think it ought to be $75 or $100?

Ms. Buto. Can I ask a question?

Mr. Donnelly. You don't usually get to ask the questions, but go ahead.

Ms. Buto. I am trying to see whether that is a set fee across the whole country, or are we going to continue to use the methodology that Medicare presently uses for reasonable costs?

Mr. Donnelly. A set fee across the whole country.

Ms. Buto. I think what——

Mr. Donnelly. If not today, is it possible for the administration to get together and make a policy decision as to how the fee ought to be set and what the fee ought to be.

Mr. Ross Anthony. Versus my just giving you an off-the-cuff answer, I think the best thing is for us to submit a detailed answer for the record so it is a thoughtful one. I would prefer to do that.

[The following was subsequently received:]

### Cost of Mammography Screening

At present, the Health Care Financing Administration does not have the data available to make accurate, up-to-date cost estimates of mammogram screening procedures. The most recent, complete data set available is from 1985.

Mammography screening is covered under Medicare as a diagnostic radiological service both in the hospital (inpatient and outpatient) and in physicians' offices. The following payments represent 1985 average allowed charges for mammographies performed in physicians' offices and are assumed to include the machine use fee and professional fees. Hospital payments are assumed to include only the professional fees.

| | Physicians' offices | Hospitals |
|---|---|---|
| Unilateral | $53 | $22 |
| Bilateral | 71 | 27 |

Mr. Donnelly. It is so ordered then. That is the answer to my uncomplicated question.

Thank you, Doctor.

Chairman Stark. Before I recognize Mr. Pickle to inquire, we will try to find out how many votes we can anticipate being clustered, but at the conclusion of Mr. Pickle's inquiry, we will recess subject to the call of the Chair. My guess is it will be in the neighborhood of 4 o'clock before we reconvene.

I apologize to the witnesses for not moving this along a little more quickly.

We will then hear from Dr. Herdman of OTA.

At this point, I will recognize Mr. Pickle.

Mr. Pickle. Mr. Chairman, I have only one or two questions.

In your testimony, Dr. Anthony, you alluded to the demonstration projects that are under way dealing with the effectiveness of preventive services. Do any of these demonstration projects deal specifically with mammography?

Mr. Ross Anthony. The two that are currently under way do not, simply because originally the amount of money that was planned to be spent for preventive services wouldn't have been enough to cover mammograms. We have five other mandated projects that will begin next year. At least one of those will cover mammagrams.

I indicated earlier that we presently have 11 applications we are evaluating, four of which would cover mammography.

Mr. Pickle. Then you have two under way, but they are not specifically for mammography?

Mr. Ross Anthony. That is correct.

Mr. Pickle. But five are coming up, and one of those will be?

Mr. Ross Anthony. At least one.

Mr. Pickle. You also indicated that the demonstration projects underway now and coming up will yield valuable information on preventive services such as these kinds of screenings. Does that mean that you or the administration oppose the bills that are pending now?

Mr. Ross Anthony. As I indicated earlier, I think that if you look at this bill and look at whether we wish to cover mammograms, I think it involves a whole larger public policy issue. Clearly, medically this is a service that is appropriate, but when you get down to it, you have to ask whether or not you wish to cover under the Medicare statute, and you being the Congress, preventive services, in particular mammograms. What it really gets to after that is a question of cost, and whether or not you are willing to pay the cost and what kind of offsets that will fund this expansion.

Mr. PICKLE. I am trying to get your specific position or that of the administration. I can understand why you want to get more information. You think valuable information will be obtained under the demonstration project, but in the absence of that information, at this time do you withhold support of the bills that are pending?

Mr. ROSS ANTHONY. We would have to withhold support until we saw what cost offsets are being proposed to pay for the program.

Mr. PICKLE. One other question. I am just trying to ask myself, where does Medicare get the money to pay for these screenings? Whether $50 is a good figure or $75 or whatever it might be, and whether they pay the 80–20 percent or whatever the figure might end up, the costs will be anywhere from $250 million to $1 billion. We don't know what it will be, and it is a needed service, but the question is this service money that Medicare is paying out in very sizable sums. How does Medicare get its money back? How does it get reimbursed? Is there any way under the bills that are pending?

Mr. ROSS ANTHONY. This would be part B service, and the way Medicare would pay for that is through a number of mechanisms. There are premiums paid by individuals, and in addition to that, there is money that comes from general revenues out of the trust fund.

I am not aware that the bill has any specific mechanism to pay for the services.

Mr. PICKLE. As much as I want to support this type of legislation or any kind of screening of this sort, and I have had some personal experience within my own family, I am also trying to find out how we keep from increasing the burden on Medicare? Medicare costs now are just zooming up, through catastrophic illnesses. We know that the premiums are going to be enormous.

I am getting complaints within my own district about this situation. Is it our intent to add this benefit in catastrophic illness legislation or in some other bill?

I don't know if you have that answer, but I raise these questions because I am concerned. How do we make the fund whole or solvent if we give this kind of service, other than just an extended cost? Can the chairman tell me that?

Do you think you would raise enough by mandatory assignment? I doubt that. I am just trying to learn, how do we pay for this?

Chairman STARK. The bill is silent, if the gentleman will yield, as to how we pay for it. It is assumed that in the present climate this won't go anywhere unless we find some other source of payment. From perhaps the Medicare——

Mr. PICKLE. I raise the question just as a matter of information or inquiry rather than recommendation, because I don't know how to approach it.

Thank you, Mr. Chairman.

[The following was subsequently received:]

### COST OF MAMMOGRAPHY SCREENING

At present, the administration does not have the data available to make accurate, up-to-date cost estimates of the mammogram screening procedure. The most recent, complete data set available is from 1985.

Mammography screening has been covered under Medicare as a diagnostic radiological service both in the hospital (inpatient and outpatient) as well as in the doctor's office. The following costs represent 1985 average allowed charges for services

**provided in the doctor's office, including the cost of administering and interpreting the test. Hospital figures represent only the cost of interpretation by the physician. Medicare data does not provide specific information on reimbursement to hospitals for administering the screening.**

| | Doctors Office | Hospital |
|---|---|---|
| Unilateral | $53 | $22 |
| Bilateral | 71 | 27 |

Chairman STARK. Thank you. Thank you very much. We appreciate both of you taking this time to counsel with us today.

We will reconvene—I understand there are only three votes—at 10 of 4, and hear from Dr. Herdman.

[Recess.]

Chairman STARK. The committee will resume.

We are honored to have Dr. Roger Herdman, Assistant Director, Office of Technology Assessment. I understand he is accompanied by Ms. Denise Dougherty, the study director.

Welcome to the committee, Dr. Herdman. We have your prepared testimony, which will appear in its entirety in the record, and if you would like to summarize or expand or review your testimony in any way you are comfortable, you may begin.

## STATEMENT OF ROGER HERDMAN, M.D., ASSISTANT DIRECTOR, OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, ACCOMPANIED BY DENISE DOUGHERTY, PH.D., ANALYST

Dr. HERDMAN. Thank you, Mr. Chairman.

We do have our written testimony on the record, and I will limit myself today to highlighting that testimony orally.

As you know, I am Roger Herdman, a physician, Assistant Director of the Congressional Office of Technology Assessment. I feel particularly comfortable today in talking about this subject because I was formerly a vice president of Memorial Sloan-Kettering Cancer Center in New York City, where I had an opportunity to become familiar with the problem that we are discussing today.

Beside me is Denise Dougherty, a Ph.D., an experienced analyst with the Office of Technology Assessment, who prepared the report, and also prepared the written testimony. I want to also recognize Dr. David Eddy from Duke who helped us with computer modeling and with the cost-effective analysis. And also to thank the National Cancer Institute and the Health Care Financing Administration, who have been very cordial and helpful in providing us with data on which we based our analysis.

As you know, this study was requested by Senator Kennedy of the Committee on Labor and Human Resources. We were also aware of your interest, Mr. Chairman, and kept your staff apprised as we went along.

In our testimony and in our study, we addressed ourselves to three questions. First of all, was mammography screening a safe and effective technology to reduce the suffering and death associated with breast cancer in the Medicare population? Second, what would be the net costs of implementing such a program? And currently what are the resources nationally to do such a program?

We know that breast cancer is the most common cancer and the most common cause of death due to cancer in the elderly female population, with 48,000 cases and 24,000 deaths each year. We know also that early detection by mammography reduces mortality by some 30 to 50 percent depending on the studies, and we know that title 18 provides mammograms for only about 4 percent of the total Medicare population each year, and that other financing programs provide only for perhaps as much as 15 percent, and we believe actually significantly less in terms of coverage for performance of mammographies in the elderly population.

Our cost-effectiveness analysis was based on a cost of the procedure of $50. We know this is usually higher, but we also know that breast cancer screenings can be performed and are being performed in this country for that amount.

It was also based on consideration that early detection reduces the initial cost of therapy by as much as $1,200, that is for stage zero to one versus stage 4 cancers, and a 2 percent false positive rate, which would lead to work-ups and biopsies in patients who did not have cancer.

Our analysis is for Medicare costs only, and did not consider other costs to society. The lives saved depends on the percent of the population screened, whether it is annual versus biannual. We chose 30 percent. We chose the population 65 to 74 years of age, and an annual examination.

For our results, the first chart I should point out to you is the increasing incidence of breast cancer with age. As you can see, it starts in the thirties or so and goes up to 85 or over, and there is a very dramatic increase with age. This is a disease which is a more serious problem in the elderly.

Put up the next table, please.

The health impact, as you see there, was a cumulative number of late stage cancers avoided by the year 2020, 85,000 in number, an average annual number of breast cancer deaths prevented of 865, and a percent reduction of 3.5 percent.

Mr. Chairman, that is the most conservative way of stating the percent reduction. That is a percent reduction which would be achieved for the whole Medicare female population, if we screened only the 65 to 74 year olds, and only 30 percent of those. If we screened that whole population, then the percent reduction would be 22 percent. The cumulative years of lives saved, as you see, is 268,000.

The financial impact was a net cost to the Medicare program in 1990 of $185 million, not discounted. The Congressional Budget Office has a slightly different figure. They arrived at it a little differently. Ours is a net cost. Theirs is a cost for implementing the procedures. As I say, ours is netted screening, plus the biopsy, minus the savings from earlier treatment. That is the cost of $18,900 per year of life saved.

The cost effectiveness would be greater if the screening was performed every 2 years, because you get about 75 percent of the benefit for 50 percent of the cost.

So one conclusion, Mr. Chairman, is that mammography is not cost saving. The question as to whether it is a good buy, of course, is a matter for the Congress to determine.

Finally, we are satisfied that the resources are available to carry out this program. In fact, there is a surplus, in our opinion, of resources, and that the risks to the women screened from the radiation are essentially negligible.

That concludes my statement, Mr. Chairman, and Dr. Dougherty and I would be happy to respond to any questions you may have.

[The statement of Dr. Herdman follows:]

TESTIMONY OF ROGER HERDMAN, M.D., ASSISTANT DIRECTOR,
OFFICE OF TECHNOLOGY ASSESSMENT,
U. S. CONGRESS
ACCOMPANIED BY DENISE DOUGHERTY, PH.D., ANALYST

BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

November 3, 1987

# BREAST CANCER SCREENING FOR MEDICARE BENEFICIARIES: EFFECTIVENESS, COSTS TO MEDICARE, AND MEDICAL RESOURCES REQUIRED

Mr. Chairman, it is my pleasure to appear before you, with results from an analysis we conducted on the topic of breast cancer screening for Medicare beneficiaries; the staff paper was requested by the Senate Labor and Human Resources Committee.

The Committee is probably aware that breast cancer is a disease that primarily afflicts older women. Figure 1 makes clear that the chances of acquiring breast cancer increase with age. As you can see, the 65 and older age group is about one and one-half times as likely as the 40-64 age group to have breast cancer. In 1987 alone, about 48,000 (44 percent) of the new primary cases and about 24,000 of breast cancer deaths will occur in women over age 65 (Health Technology, 1987).[1]

Although epidemiological evidence has suggested a number of risk factors for breast cancer, the causes of this virulent disease is not known. Early detection -- typically involving breast physical examination and mammography -- has thus been heralded by the American Cancer Society and other health organizations as the best means of preventing the debilitation and death associated with advanced breast cancer.

But third party payment, including Medicare reimbursement, is not generally available for screening examinations. Insurers, including the Federal Government, have been concerned that the cost of reimbursing for such examinations would be high, relative to their effectiveness in detecting breast cancer. Medicare benefits are limited primarily to paying for acute care for illness after diagnosis. Medicare pays for only two primary prevention activities -- vaccinations for pneumococcal pneumonia and hepatitis B. Concern has also been expressed about the safety of mammography procedures, and the availability of the necessary resources should a widescale screening program begin.

The Senate Labor and Human Resources Committee, concerned primarily about older women, the group most at risk, which is also the group for whom a Federal program for medical care coverage is already in place, asked OTA to examine the questions of:

- whether breast cancer screening would be a safe and effective means of reducing premature mortality in the 65 and over female Medicare population;
- what the net costs to Medicare would be of paying for breast cancer screening for Medicare beneficiaries; and
- whether the equipment and medical staffing resources for providing such a benefit are available.

As part of our analysis, we also evaluated whether there is a need for a screening reimbursement for Medicare beneficiaries or whether American women aged 65 and older are already participating in screening programs to the extent possible.

We should emphasize that our analysis of the effectiveness of breast cancer was limited to the population 65 and over, and to the costs and cost-savings that Medicare would be expected to experience should breast cancer screening be reimbursed, not any costs or savings to society as a whole or individual women, although these impacts are touched on in our testimony here today.

This testimony summarizes the way we proceeded with our analysis and the results of that analysis. A staff paper to be released this week will provide more details of the analysis, and give the results of making a greater range of assumptions about breast cancer screening for Medicare beneficiaries than can be described here.

## The Need for Screening

We found that, as you will undoubtedly hear again today, despite advances in detection and treatment in recent years, breast cancer remains a common disease of American women, and a particularly virulent one, in medical, emotional, social, and economic terms.

In its early stages (Stages 0, I and part of Stage II; see Table 1), breast cancer is a relatively curable disease. Unlike lung and some other cancers, breast cancer is relatively indolent, that is, it takes longer to develop and a diagnosis is less likely to mean an almost sure death sentence. However, if left undiagnosed until its later stages, breast cancer is more likely to spread to many sites in the body and cause premature death. The emotional impact of being diagnosed with a late stage breast cancer and the social and financial impact on families, friends and co-workers can be devastating.

Advanced stage breast cancer will likely involve the use of chemotherapy or radiotherapy or both, in addition to surgical removal of all or part of the breast and other tissues; these treatment methods are both costly economically and can cause considerable side effects, adding to the morbidity and suffering involved with breast cancer. There is as well a significant emotional component to the loss of a breast, no matter what the woman's age. If breast cancer is diagnosed at an early stage, on the other hand, there is considerable evidence that life can be prolonged and severe morbidity and its associated medical, emotional and economic costs can be avoided in many patients.

One might expect that women would take care to be screened regularly for breast cancer. But our review of available information indicated that most women are not screened regularly for breast cancer. There are several reasons why breast cancer screening is underutilized by women in all age groups:

o Fewer women than need to be are clinically examined for breast cancer by their physicians, or referred by their physicians for screening mammography;

o Fears about excess radiation persist;

o Fear of a cancer diagnosis; and

o The expense; as I noted earlier, the cost of mammography alone usually is not covered by insurance, and it ranges from about $40 to $100, $200, or even more. The cost of a breast physical examination, which is deemed an essential adjunct to mammography, is usually extra. These charges may make breast cancer screening financially out of reach, especially for the 15 percent of women 65 and over existing at or near the poverty level of about $6,000 a year (U. S. Department of Commerce, 1985; The Villers Foundation, 1987).

Taking all these factors into consideration, it is perhaps not surprising, then, that all available evidence indicates that the older the woman, the less likely she is to perform breast self-examination, or have an annual clinical breast examination or an annual mammogram. For example, in 1985, only 4 percent of Medicare enrollees appeared to have received mammographic examinations paid by Medicare; most of these are believed to be diagnostic, rather than screening, mammograms (USDHHS, HCFA, 1987). (Diagnostic examinations are conducted in response to a patient presenting a symptom, such as a lump in the breast; screening examinations are typically done on asymptomatic individuals.) As a result of the lack of screening, older women are more likely to be diagnosed with late stage breast cancer (Allen et al., 1986).

## Effectiveness and Costs of Breast Cancer Screening

### Sources and assumptions.

OTA used a variety of sources to estimate the effectiveness and costs of breast cancer screening for Medicare beneficiaries. A summary of the assumptions derived from these sources is shown in Table 1. Briefly:

o We assumed that screening reduces mortality 50 percent at five years, and that this effect gradually decreases to 30 percent survival at 20 years. Shifts in stages were chosen to achieve the assumed reduction in mortality at each followup period.

o Costs of screening to Medicare were estimated from instances of current practice, Medicare data (USDHHS, HCFA, 1987), and assumptions about future practice. A key assumption for our base case analysis was that screening -- including a breast physical examination and a mammogram -- could be obtained for $50, or that Medicare would restrict payment to that amount. While the cost of a mammogram alone, in centers which do not distinguish between charges for screening and diagnostic mammograms can be over $200, a small number of breast screening programs have shown that a combination of medical history taking, breast physical examinations, instruction in breast self-examination, and even follow-up, can be provided for between $25 and $45 (Bird & McClelland, 1986; Sickles, 1986; Strax, 1984, 1987). This cost assumption may mean that a non-physician, but technically trained person, would perform the breast physical examination.

o We also assumed that women accepting screening would already have paid their $75 deductible for an outpatient visit as a result of another encounter during the year they were screened.

- o It turned out that one of our assumptions about the costs of screening that implied high costs is the number of false positive examinations that would result in a recommendation for a biopsy. We assumed that two percent of the screening examinations would result in a recommendation for a biopsy, and that the average cost to Medicare of these additional biopsies due to false positive screening examinations would be $900 per workup.

A key expectation of a cost-effectiveness analysis of a prevention program such as breast cancer screening is that prevention results in savings due to lower costs of treatment. Thus, it was central to our analysis to estimate the reduction in costs to Medicare of breast cancer treatment that might result by detecting more cancers at earlier, and thus less costly stages. Unfortunately, there are no Medicare data on cost per stage of the illness.

- o Available data indicated that: 1) there is a difference of about $1,200 between initial treatment for Stage 0 breast cancer (carcinoma in situ), the earliest stage, and Stage IV breast cancer, 2) the breast cancer-specific cost to Medicare for continuing care was $183 per month, and 3) the cost to Medicare for terminal care for breast cancer was $10,776 and for all causes of death $7,618.

  These are the best and most complete current estimates of the costs to Medicare of breast cancer diagnosis and treatment, based on an extensive analysis of Medicare data by the National Cancer Institute (Baker, Kessler and Smucker, 1987; in preparation). However, we should emphasize that NCI's analysis was conducted with data collected between 1974 and 1981, and may not reflect current treatment. We should also emphasize that there are many costs of breast cancer diagnosis and treatment that are borne either by so-called "Medigap" insurance, which reimburses patients (or providers) for charges not paid by Medicare, or by the individual patient. These costs have not been collected or analyzed systematically.

Other important factors in estimating the effectiveness and costs to Medicare of breast cancer screening are the the proportion of women who actually accept screening and the frequency with which women are or can be (because of policy decisions) screened. As we noted before, the proportion of women 65 and over who are currently screened regularly for breast cancer appears to be extremely low. Studies of women over 45 have found the utilization of regular breast cancer screening to be 2 percent, 5 percent, or 15 percent. These and other studies indicate that the use of mammography decreases with age; however, none of them reported the use of mammography by women 65 and over as a separate group. In contrast to these low utilization rates, 80 percent of women in the recent screening trial in Sweden participated in regular screening, and 50 percent of the women offered screening in a U. S. trial conducted by an organized health care plan in the 1960s participated, demonstrating perhaps that an organized effort to have women participate in screening can be effective.

- o For our base case analysis, we assumed that women aged 65 to 74 would be the most likely to accept screening, and that 30 percent of asymptomatic women in that age group would be screened annually if costs were to be reimbursed.
- o Finally, we also assumed that the screening program would begin in 1987, and that treatment for breast cancer is effective.

Calculation Method.

A computerized mathematical model developed by Dr. David Eddy of Duke University, in conjunction with the National Cancer Institute and their advisors, was used by Dr. Eddy, under contract to OTA, to perform the calculations necessary to estimate the effectiveness and costs of screening. The calculation methods are complicated and are described more fully in our forthcoming staff paper and in Eddy (1986). Briefly, the computer model simulates what would actually happen if a screening program were introduced in a population, keeping track for each future year of such outcomes as how many women are eligible for screening, how many are diagnosed as having breast cancer (by stage), how many carry the diagnosis of breast cancer, and how many die of breast cancer or other causes. It also calculates the financial costs associated with all the important events (e.g., screening, workups, treatment).

Results

Life years saved and suffering avoided. As you can see from our summary table (Table 2), the base case analysis estimated that a screening program begun in 1987, in which 30% of female Medicare beneficiaries age 65 to 74 accepted annual screening, would result in the avoidance of an average of 2,500 late stage breast cancers every year from 1990 to 2020, with a total of 85,041 late stage breast cancers prevented by the year 2020, and 267,000 person years of life saved by 2020.

Summary statements of the effectiveness of screening can be confusing because the effects depend on the population being considered, the assumptions made about the proportion of women who accept screening, and the frequency with which they are screened.

To pick one example (see Table 3), there would be a 3.5 percent reduction in breast cancer deaths (that is, 828 fewer breast cancer deaths) in the year 2000, were there to be annual screening and acceptance by 30 percent of women aged 65 to 74, the assumption made in our base case analysis. If all women 65 and older were screened between now and the year 2000, there would be 5,200 fewer breast cancer deaths in 2000, a reduction of 22 percent in this age group. We might note that the Federal Government has set itself a goal of reducing deaths from all cancers in all age groups by 50 percent by the year 2000. Thus, it seems that regular breast cancer screening would help to meet this Federal goal.

Put in terms of an individual average-risk 65 year old women (that is, one who has only a 5 percent chance of developing breast cancer in the rest of her life), who is screened annually from age 65 to 74, the increase in life expectancy is about 13.4 days. For a woman who is destined to get breast cancer after age 65, such a screening regimen would increase her expected lifetime by about 258 days, and would reduce the probability she would die of breast cancer by about 19 percent.

Costs to Medicare. As for costs to Medicare, no matter which assumption we used, our analysis showed that breast cancer screening cannot be expected to save enough money in decreased treatment costs to offset the costs of screening and workups. While, as shown in Table 4, there are savings due to a reduction in initial and terminal treatment costs for breast cancer, the cost of screening itself far exceeds these savings. In addition there are the costs of workups due to additional false positive screening results, and continuing management and treatment for those women kept alive longer with a diagnosis of breast cancer. For example, screening 30 percent of women age 65-74 will involve screening approximately 3,000,000 women each year and working up approximately 55,000 women each year for false-positive test results.

Our base case analysis resulted in an estimate that a breast cancer screening program paid for by Medicare program would cost Medicare about $185 million in 1990, if costs were undiscounted, or $160 million if costs were discounted at 5 percent. The cost to Medicare per life-year saved in 2020 is approximately $28,000, undiscounted; $13,200 with discounting of costs alone.

To help put these potential estimated costs in context, $185 million represents less than one-half of one percent of the $71 billion of Medicare expenditures in 1985 (Waldo, et al., 1986). On the other hand, if all women 65 and over accepted screening, the net cost to Medicare in 1990 would be $1.5 billion. This is, however, an unlikely event.

Biennial Screening. The effects of biennial mammography and breast physical examination have been estimated under the assumption that biennial examinations will deliver 75% of the effectiveness of annual examinations. The results of screening 30% of women age 65 through 74 are shown in Table 5. In the year 2000, there would be about 600 fewer breast cancer deaths and 1,800 fewer late stage cancers under biennial screening, instead of 830 fewer deaths and 2,300 fewer late stage cancers under annual screening. Of course, biennial screening would reduce the cost of screening, the number of false-positive results, and the cost of workups each year by a factor of two. We estimate that the discounted net cost in 1990 for biennial screening, if 30 percent of women aged 65 through 74 accepted screening, would be $79 million, half that of annual screening of the same group.

### Medical Resources for Screening

It is, of course, not possible to predict the precise number of screens that would be done if reimbursement were available, but OTA found no evidence of a current shortage of breast cancer screening services in the United States overall; on the contrary, it appears that resources for breast cancer screening are underutilized, at least in part because neither women nor their physicians follow current recommendations regarding screening. Our summary of the availability of and requirements for health care personnel and mammographic equipment under an assumption of annual screening, with 30 percent of women aged 65-74 accepting screening, are shown in Table 6. To demonstrate the sensitivity of our analysis of resources, we also show the requirements should all asymptomatic women 65 and older decide to accept breast cancer screening.

In our analysis of the resources required for screening, one of our key assumptions was that, as a number of breast screening centers have demonstrated, one dedicated screen-film mammographic unit operating at reasonable efficiency can perform an average of 30 examinations per 8 hour day, or about 7,500 examinations a year. We also assumed that three radiological technologists can manage a freestanding breast screening program with one dedicated mammographic unit -- a liberal estimate -- and that a single radiologist can evaluate 30 film-screen mammograms in an hour.

At least 4,900 dedicated mammographic units are operating in the United States now, and more than 1,500 units are being installed annually -- a rapid pace. There is an apparent surplus of physicians in the United States, and the field of diagnostic radiology is experiencing above average growth. Radiologic technologists and other support staff can be trained as needed.

One exception to our estimate that an adequate amount of equipment and an adequate number of health professional are available to perform breast cancer screening concerns the health professionals that would be needed to perform breast physical examinations and instruct women in breast self-examination. Several breast screening programs have shown that nonphysicians can be trained to do at least the initial phase of the examination, although physicians would be required to assess suspicious lumps. We expect that nurses, nurse-practitioners or similar personnel would perform breast physical examinations. But as you may be aware, there is an apparent shortage of nurses. So, excepting provider preferences for subspecialization, the only group of health professionals who might be in short supply are nurses. A further caveat, however, is that we were not able to compare the availability of resources to possible requirements in specific geographic areas of the country. Anecdotally, we became aware, however, that some areas of the country have a far greater supply of resources for screening than others. In the results shown in Table 6, we made a rough adjustment for the greater resource needs required by the geographic dispersion of the population.

We would also like to point out, that although capacity to meet increased demand for breast screening services in the Medicare population should not be a problem over the long term, the need to monitor the quality of screening services should be anticipated, especially if Medicare expects to restrict the amount to be reimbursed to providers of screening services. While the Food and Drug Administration (FDA) has responsibility for monitoring radiographic equipment sold and installed in the United States, there are other aspects of breast cancer screening procedures that can affect the quality of the results and the rapid expansion of new freestanding breast screening services is likely to raise concerns about the quality of the services provided. An American College of Radiology mammography accreditation program will establish quality standards, because most screening programs will be designed for ACR accreditation to ensure recommended listing by the American Cancer Society. This program is, however, in its beginning stages, and its actual contribution to quality screening has not been evaluated. But perhaps Medicare could decide to pay only for screening services provided in ACR-accredited facilities.

## Risks of Screening

Assuming the use of dedicated mammography equipment and quality control, the carcinogenic effect of modern mammography for women over age 65 is relatively negligible. The dose currently used for mammography is (or should be) very low. If there is any risk, it is expected to cause fewer than five new breast cancer cases in one million 65-year-old women over the remainder of their lifetimes if they are screened with mammography ten times between ages 65 and 74.

There are, however, some risks associated with a false positive breast physical or mammogram which may be of concern to individual women. OTA estimates that as many as 2 percent of women screened will have false positive examinations requiring additional diagnostic tests and often surgical biopsies. While a combination of breast physical and mammography is the best available noninvasive means of screening, positive results of either test must still be confirmed with a biopsy, usually a surgical one. This procedure is uncomfortable and carries with it the risk of infection and, if done under a general anesthetic, the risk of complications associated with any surgical procedure.

## Limitations and Sensitivity of our Analysis

A number of limitations to our analysis should be considered, and other assumptions are, of course, possible.

For example, we may be underestimating to some extent the number of Medicare beneficiaries who are receiving regular screening. Medicare beneficiaries participating in HMOs and other capitated payment plans may already be receiving breast cancer screening; Medicare would have no independent record of such screenings. However, the number of such women is still small.

We may be underestimating the potential effectiveness of treatment for women 65 and over. The impact of screening on breast cancer mortality depends on effective treatment. Breast cancer treatment has changed since the studies on which our screening effectiveness assumptions were begun, and may be more effective in the future. However, several recent studies indicate that older women do not receive the same level of breast cancer treatment as younger women do, even though retrospective analyses judged some older women to be just as able to withstand aggressive treatment as younger women are (Chu et al., 1987; Wetle, 1987). If treatment improves, the impact of screening would be enhanced.

OTA's analysis was not able to take into consideration a number of options which might be considered by the Federal Government to reduce the cost of breast cancer screening to Medicare, although this may mean shifting the cost to other payors. The costs of breast cancer screening might be less under capitation payment; some HMOs already include breast cancer screening, including mammography, as part of their benefits. Another option might be to make breast screening a public program. Such an option would probably be associated with making coverage for breast cancer screening available only to those who cannot afford to pay for it otherwise (that is, through a means test). Medicare could explore such an option also, although there is no precedent for it in Medicare.

We could assume that all women age 65 and over would accept screening, or that screening would be offered every three years, or that the various costs should be different would be different; a range of analyses using a number of different assumptions will be presented in our forthcoming staff paper. It is worth noting here that no matter which assumption we used, our analysis indicates that breast cancer screening for women 65 and older would be effective in terms of breast cancer deaths and morbidity avoided. However, the costs of screening do not seem to be neutralized no matter what assumptions we use about the costs of screening or treatment.

## Conclusion

As the population grows older, we can expect the number of women over the age of 65 with breast cancer to increase. Clearly, increased use of breast cancer screening would considerably reduce the severe morbidity, premature mortality, and, to some extent, treatment costs associated with advanced breast cancer. The lives of many women would be prolonged and there would be considerably less suffering if most women 65 and over were to be diagnosed early in the disease process. Unfortunately, the number of screens required to detect a single breast cancer is high, and the economic cost to Medicare per breast cancer screen, even using conservative assumptions, is high. These factors offset the savings that would be achieved in treatment costs, resulting in a net economic cost to Medicare if screening were to be introduced. However, it has been pointed out that it seems somewhat unfair for a relatively low cost program like breast cancer screening to bear the burden of demonstrating that it is cost-effective. There are a considerable number of expensive procedures and diagnoses for which Medicare pays, which are sometimes performed in the absence of demonstrated need and effectiveness (e.g., USDHHS, OIG, August 1987). The fact that breast cancer screening does not save money should not, by itself, cause rejection of the program. Extremely few health activities, whether they are for diagnosis, treatment or rehabilitation, save money. Rather the purpose of health care is to spend money to improve the health of people.

We do want to mention, in addition, that mere reimbursement for breast cancer screening may not be enough to induce women to be screened regularly. As we said earlier, there are a number of other reasons that women and physicians give -- and there are probably reasons that they are not consciously aware of -- for noncompliance with screening recommendations. Whether screening is reimbursed or not, an effort to convince both women and physicians of its effectiveness seems in order.

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[1] The number of new cases represents the number of new primary cases, and excludes second breast cancers in women previously diagnosed with breast cancer. The total number of new breast cancer cases in 1967 is expected to be approximately 130,000.

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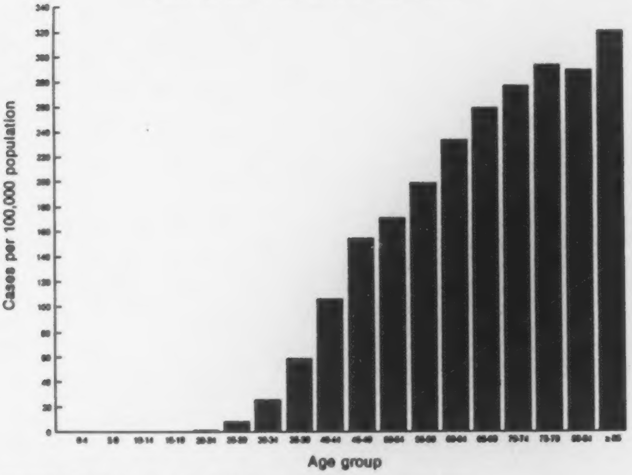
Figure 1

NEW PRIMARY BREAST CANCERS—1987



SOURCE: OTA, Calculated by Dr. David Eddy based on data from NCI, SEER.

Breast Cancer Screening
for Medicare Beneficiaries:
Effectiveness, Costs to Medicare and Medical Resources Required

## TABLE 1
## SUMMARY OF ASSUMPTIONS FOR BASE CASE ANALYSIS[1]

- Screening includes annual breast physical examination (BPE) and mammography
- The combined false-positive rate of the two examinations is 2%.
- 30% of women aged 65-74 offered screening will accept.
- The group of women who accept screening have an average risk of developing breast cancer.
- Screening reduces mortality by 50% at five years, gradually decreasing to 30% at 20 years[2]
- Shifts in stages were chosen to achieve the assumed reduction in mortality at each followup period.[3]
- Costs to Medicare:

| | | |
|---|---|---|
| Screening mammogram and BPE | $ | 50 |
| Workup for false positive | $ | 900 |
| Difference in Costs of initial treatment[4] between Stages 0 and IV | $ | 1,200 |
| Continuing care (per month)[5] | $ | 183 |
| Terminal care - breast cancer | $ | 10,778 |
| Terminal care - other causes | $ | 7,618 |

- Women accepting screening would already have paid their $75 deductible as a result of receiving other care.

[1] A method for exploring the impact of other assumptions is described in OTA's forthcoming staff paper.

[2] Because none of the research studies matches the target population precisely, there is considerable uncertainty about the actual effectiveness of screening in reducing mortality. The baseline assumption is one estimate made to indicate the approximate magnitude of the effect. It is based loosely on results of the HIP study (Shapiro et al, 1985) but includes consideration of 4 other controlled studies of screening.

[3] Shifts in Stage Achieved by Screening[a]

| | Stage Proportions:<br>Without Screening | Stage Proportions:<br>With Screening |
|---|---|---|
| Stage 0 | 0.051 | 0.050 |
| Stage I | 0.248 | 0.400 |
| Stage II | 0.534 | 0.550 |
| Stage III | 0.081 | 0.000 |
| Stage IV | 0.086 | 0.000 |

[a] There are no data from controlled trials on how screening changes the proportion of cancers detected in each stage for women age 65 and over. For purposes of estimating changes in morbidity, we considered the results of the Breast Cancer Detection Demonstration Project (BCDDP) (Seidman et al., 1987) which is the only project which reported results by stage. However, BCDDP was not a controlled study and the reported results apply to women over 50 (not 65) so the estimate of late stage cancers avoided that is derived from BCDDP may be somewhat overstated.

[4] Defined as care delivered in the first three months followed diagnosis.

[5] Difference between cost of breast cancer and cost of other causes of death.

Breast Cancer Screening for Medicare Beneficiaries: Effectiveness, Cost to Medicare and Medical Resources Required

## TABLE 2

## SUMMARY OF RESULTS FOR EFFECTIVENESS[1]

### BREAST CANCER SCREENING FOR MEDICARE BENEFICIARIES AGED 65 AND OVER IS EFFECTIVE

### ANNUAL SCREENING IS MOST EFFECTIVE BUT MORE COSTLY TO MEDICARE

| DEATH AND SUFFERING IN THE ENTIRE 65 AND OLDER FEMALE POPULATION AVOIDED WITH ANNUAL SCREENING OF 30 % OF WOMEN 65-74 | |
|---|---|
| Cumulative Number of Late Stage Cancers Avoided by the Year 2020 | 85,000 |
| Average Annual Number of Breast Cancer Deaths Prevented 1990-2020 | 865[2] |
| Percent Reduction | 3.5%[7] |
| Cumulative Number of Person Years of Life Saved 1987-2020 | 268,000 |
| Risk to an individual woman of acquiring a new case of breast cancer due to mammographic x-rays | Less than 1 in 500,000 |

*Notes*

1 See Table 1 for summary of assumptions used in the base case analysis.
2 Roughly calculated by adding together the number of breast cancer deaths prevented in the years 1990, 1995, 2000, 2005, 2010, 2015, and 2020 and dividing by 7.
3 The increase in life expectancy for a woman who is screened (and has only about a 5 percent chance of developing breast cancer in the rest of her life) is about 13.4 days.
4 The American College of Radiology is beginning a certification program for breast screening centers, but is voluntary and not yet fully operational. Only 17 States license radiologic technologists.
5 Lurie, et al., 1987.
6 Several studies indicated that older women recieve less than adequate treatment (see forthcoming OTA staff paper).
7 In the year 2000.

## TABLE 3

## THE ANNUAL IMPACT ON MORTALITY AND MORBIDITY
## OF SCREENING 30% OF ASYMPTOMATIC WOMEN IN THE U.S.
## AGE 65 THROUGH 74
## WITH ANNUAL BREAST PHYSICAL EXAMINATIONS AND MAMMOGRAPHY
## 1987 TO 2020

USES BASELINE ASSUMPTIONS

| | | | Impact on Breast Cancer Deaths | | | | Impact on Breast Cancer Morbidity | |
|---|---|---|---|---|---|---|---|---|
| | | | Annual Impact | | | | | |
| Year | # Women 65-100 in the US (1) | # Cases (2) | No Screening (3) | With Screen (4) | Diff. (5) | Cumulative* # of Person-Years of Life Saved (6) | Annual # of Late Stage** Cases Prevented*** (7) | Cumulative* # of Late Stage** Cases Prevented*** (8) |
| 1990 | 17,865,000 | 49461 | 21108 | 20537 | - 571 | 3421 | 2241 | 8925 |
| 1995 | 18,405,000 | 51297 | 22602 | 21835 | - 767 | 20394 | 2255 | 20171 |
| 2000 | 18,894,000 | 52915 | 23714 | 22886 | - 828 | 51907 | 2312 | 31587 |
| 2005 | 19,663,000 | 55242 | 24883 | 24009 | - 874 | 94929 | 2450 | 43528 |
| 2010 | 20,802,000 | 58560 | 26378 | 25442 | - 936 | 146352 | 2649 | 56362 |
| 2015 | 22,189,000 | 62544 | 28183 | 27176 | -1007 | 204269 | 2866 | 70237 |
| 2020 | 23,516,000 | 66497 | 30081 | 29007 | -1074 | 267782 | 3023 | 85041 |

*Calculated from 1987

**Stage II greater than 5 cm or with positive nodes, Stage III, or Stage IV

***Detected while in early stages (stage 0, I, II <5 cm)

## Breast Cancer Screening for Medicare Beneficiaries:
## Effectiveness, Costs to Medicare and Medical Resources Required

## TABLE 4

## SELECTED SUMMARY RESULTS FOR NET COSTS AND COST EFFECTIVENESS TO MEDICARE[1]

| COSTS TO MEDICARE WITH ANNUAL SCREENING OF 30% OF WOMEN 65-74 | | |
|---|---|---|
| ESTIMATED FINANCIAL COSTS TO MEDICARE IN 1990 | | |
| | Without Discounting | With 5% Discounting |
| Screens | $138,600,000 | $119,800,000 |
| Workups | 49,900,000 | 43,100,000 |
| Initial Treatment | -1,000,000 | -900,000 |
| Continuing Treatment | 3,500,000 | 3,000,000 |
| Terminal Treatment - Cancer | -6,200,000 | -5,300,000 |
| Terminal Treatment - Other | 300,000 | 200,000 |
| Annual Net Cost to Medicare in 1990 | $185,100,000 | $159,900,000 |
| COST-EFFECTIVENESS TO MEDICARE | | |
| Cost per life-year saved[2] by 2020 | $ 28,000 | $ 13,200 |

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1 See Table 1 for Assumptions of the Base Case Analysis.

2 Health effects not discounted. Disagreement exists among analysts about whether health effects should be discounted in cost-effectiveness analysis. Under an assumption in which both cost and health effects would be discounted, the cost to Medicare per life-year saved by 2020 would be approximately $34,600.

TABLE 5

THE ANNUAL LOGISTIC AND FINANCIAL IMPACT
OF SCREENING 30% OF ASYMPTOMATIC WOMEN IN THE U.S.
AGE 65 THROUGH 74
WITH BIENNIAL BREAST PHYSICAL EXAMINATIONS AND MAMMOGRAPHY
1987 TO 2020

| | No. Examinations and Workups (000s) | | Estimated Financial Costs to Medicare (000s $)* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. Screens (9) | No. Workups (10) | Screens (11) | Workups (12) | Init'l Rx (13) | Cont'g Rx (14) | Term'l Rx Cancer (15) | Term'l Rx Other (16) | Annual Net Costs (17) | Cumulative Net Costs (18) |
| 1990 | 1306 | 27.7 | 59,084 | 21558 | - 599 | 2357 | - 4094 | 163 | 79,274 | 339,825 |
| 1995 | 1396 | 27.9 | 47,228 | 17002 | - 472 | 5195 | - 4102 | 615 | 66,466 | 692,995 |
| 2000 | 1432 | 28.6 | 37,958 | 13665 | - 379 | 6348 | - 3434 | 1008 | 55,166 | 988,266 |
| 2005 | 1519 | 30.4 | 31,549 | 11358 | - 315 | 6313 | - 2862 | 1206 | 47,248 | 1,239,611 |
| 2010 | 1643 | 32.9 | 26,744 | 9625 | - 267 | 5734 | - 2418 | 1214 | 40,634 | 1,455,679 |
| 2015 | 1771 | 35.4 | 22,593 | 8133 | - 226 | 5001 | - 2048 | 1114 | 34,588 | 1,640,512 |
| 2020 | 1874 | 37.5 | 18,729 | 6743 | - 187 | 4273 | - 1712 | 975 | 28,820 | 1,796,973 |

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*1984 dollars, discounted at 5% from 1987

Breast Cancer Screening
for Medicare Beneficiaries:
Effectiveness, Costs to Medicare and Medical Resources Required

## TABLE 6.--SUMMARY OF RESULTS FOR MEDICAL RESOURCES REQUIRED

**IN GENERAL, RESOURCES ARE ADEQUATE**

| RESOURCES REQUIRED IN 1990 | Available Now | Base Case Estimate[1] Requirements[2] | Maximum Requirements[2] |
|---|---|---|---|
| *Number of screening examinations* | | *2.8 million* | *17.4 million* |
| **Dedicated[3] mammography units[4]** | 4,900[5] | 460 | 2,323 |
| **Diagnostic radiologists[6]** | 13,000[7] | 60 | 290 |
| **Radiological technologists[8]** | 160,000[9] | 1,400 | 6,970 |
| **Health professionals qualified to do breast physical examinations[10]** | 400,000[11] | 1,700 | 10,900 |

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[1] See assumptions in Table 1. Basically, the base case assumes annual screening for 30% of asymptomatic women 65-74 years old.

[2] To adjust for the geographic distribution of the population aged 65 and over (approximately 26% rural [U. S. Department of Commerce, Bureau of the Census, 1985]), we multiplied the number of machines and health professionals required to perform breast physical examinations by a factor of 1.25.

[3] Dedicated means used only for mammography and not for other radiologic diagnostic purposes.

[4] Assumption is that one mammography machine performs approximately 30 examinations daily or 7,500 examinations a (250 workday) year.

[5] Source: American College of Radiology, the U. S. Food and Drug Administration, and other sources cited in OTA's forthcoming staff paper.

[6] Assumption is that screening mammograms can be interpreted by radiologists at the rate of approximately 30 per hour: that is, the average daily output of one mammography machine, 30 examinations, can be interpreted in 1 hour of a radiologist's time, or in 12.5 percent of a radiologist's 8 hour day. Put more simply, the number of machines divided by 8 gives the number of radiologists required to meet the assumed demand.

[7] This figure includes all diagnostic radiologists. Source: American Medical Association and other sources cited in OTA's forthcoming staff paper.

[8] Each mammography machine is operated by a staff of three radiological technologists (or similar staff).

[9] As with diagnostic radiologists, this includes all radiological technologists, not just those who may subspecialize informally in mammography. The figure may be an underestimate because it includes only those registered with the American Registry of Radiological Technologists.

[10] Calculation for the base case estimate: 2,773,000 breast physical examinations divided by 8 per day = 347,000 person days, divided by 250 work days per year = 1,386 health professionals. This number was then multiplied by a factor of 1.25 to adjust for the geographic dispersion of the population, and rounded. For the maximum requirement, substitute 17,427,000 exams, 2,178,375 person days, and 8,714 health professionals.

[11] Includes 188,000 physicians in either Family Practice, General Practice, Internal Medicine or Obstetrics/Gynecology (AMA, 1986), 15,000 nurse practitioners, 16,000 physician assistants, 2,000 certified nurse-midwives (all from OTA, Nurse Practitioners, 1986), and 186,000 registered nurses. As with radiologists and radiological technologists, the figures for health professionals qualified to perform breast physical examinations includes all available personnel. If the examination were to be performed by non-physicians, the current nurse shortage should be considered.

Chairman **Stark**. Thank you. If we could pay for one preventive or diagnostic treatment—mammography is not necessarily a preventive treatment, it is diagnostic, right?

Dr. **Herdman**. I heard that discussion earlier. It really is, I think. There are a number of ways of defining prevention, primary, secondary, tertiary prevention. I think that mammography as a screening technology, as applied to populations not on an individual, where you apply it on a set formula, a set period to a defined population can be defined as a preventive technology.

Chairman **Stark**. If there was one particular preventive or diagnostic technique or routine that we ought to provide to all Medicare beneficiaries, would you pick this one? In other words, let's say we take my figure of $50. I am not sure that you could get a medical exam for $50, but you might get one for $100. It might be pretty cursory and it might not be many tests, but just in your personal opinion, are we apt to not be picking the right diagnostic or preventive procedure here, just because this mammography has had more attention because of recent happenings?

Dr. **Herdman**. Well, as you know, Mr. Chairman, you have asked us to look at exactly that question, and clearly I can't give you the results of our study in this way. I think that what we feel is that there are a number of effective preventive technologies for the Medicare program. Pap smears would certainly be one, pneumococcal and hepatitis vaccines, which are already covered, would be another. All of these I think are underutilized, and I think mammography clearly is yet another, and there may be additional ones which we will be able to determine as we study this more carefully.

Which one I would pick is hard to say. Clearly, mammography is one of the more expensive technologies, and indeed pneumococcal vaccine is one of the cheapest, but it clearly does the job.

Chairman **Stark**. Again, I guess in your professional and/or personal opinion, there is a danger that we are going to keep all our moving parts and each time we prevent some particular disease or disintegration, one other will occur, and that maybe we just ought to reverse this and start somewhere around my age, and put people into a preventive program with annual physicals. I have a hunch then we will all live longer and possibly cost more.

It is like price and quality at A&P. I am never quite sure whether we should be talking about price or quality.

Is it your opinion that if we did annual physicals, and a lot of preventive care, that we would extend the overall costs of Medicare because of the extended life span? As a physician, does that make sense to you, or are we just going to all hit a finite limit and drop over the edge any way?

Dr. **Herdman**. I think it is clear that there is a biological limit to life. It may not be quite so clear, but I think that that is pretty generally agreed.

Chairman **Stark**. It is hard to convince Congressmen of that.

Dr. **Herdman**. And I think it is also clear that mankind is more interested in the redemption of sin than a blameless life, which is why we have trouble with preventive technologies. And I think it is also an interesting fact that the curative technologies, even if they cost $1 or $2 billion added to the program without any discussion, without any concern about cost, although we are, as you are and we all are concerned about the costs—but the preventive programs, because the statute doesn't include that as a concept, have to be argued about, and added piecemeal.

I don't want to come before you and oversell what prevention can do, although I think that it can do a lot. It is also clear that it is hard to prove, and we would not tell you that preventive technologies added to the program by and large are going to be cost saving. The program is to deliver health care to the citizens of this country. It is supposed to improve their health and longevity, and it is going to cost money to do that, as we all know, and we will try to find out for you how much it costs to add each preventive technology and how effective it is.

Chairman **Stark**. Would you as a potential Medicare beneficiary, rather have us make available heart transplants or a broad range of annual physicals and preventive or diagnostic services?

Dr. **Herdman**. I think your question would be some array of effective preventive technologies; of course I would rather have that.

Chairman **Stark**. And does it make sense to you that if we started to include a few very expensive procedures, like organ transplants and things like that, we would probably end up spending more on a very small number of people than we might on a broader spectrum of the population?

Dr. **Herdman**. It would cost more, probably, than mammography, but I would have to check that. I am not sure about that.

Chairman **Stark**. Dr. Dougherty, did you want to add anything to the discussion here? I guess I should ask some of the questions that have been asked before.

Do you see any problem with a $50 cap on this payment?

Dr. **Herdman**. We know that the service is being delivered, that is the x ray itself, the interpretation of that film, and in fact also an examination, a breast examination of the patient for that amount. In fact, I am not sure, but doesn't your bill allow for actually a higher fee? If you said Medicare is going to spend $50, wouldn't the actual fee allowed be $60 something?

Chairman **Stark**. No, it is the other way. Medicare would actually end up paying $40 and the patient would pay——

Dr. **Herdman**. The actual charge.

Chairman **Stark**. A patient on Medicaid——

Dr. **Herdman**. Some of the witnesses that are going to follow me would have more information to tell you than I, but we do know that those services can be delivered for $50. It is also true that they usually are not delivered. They are usually delivered for substantially more. And I am not the one to say whether that is reasonable or not, but it is possible, certainly.

Ms. **Dougherty**. But I might want to be sure to monitor the quality task delivered, whatever the reimbursement is, if you start a large-scale program.

Chairman **Stark**. That is a point well taken. I want to thank you both for the study and for being here to testify, and apologize for the delays that kept you sitting here all this time.

I call our next witness, who is Dr. Myron Moskowitz, professor of radiology, representing the American Cancer Society.

## STATEMENT OF MYRON MOSKOWITZ, M.D., DIRECTOR OF BREAST IMAGING, AND PROFESSOR OF RADIOLOGY, UNIVERSITY OF CINCINNATI MEDICAL CENTER, REPRESENTING THE AMERICAN CANCER SOCIETY

Dr. **Moskowitz**. Thank you, Mr. Chairman.

Chairman **Stark**. Welcome to the committee, Doctor. We will put your entire prepared statement in the record, and you may summarize or proceed to enlighten me in any way you are comfortable.

Dr. **Moskowitz**. Mr. Chairman and members of the committee, thank you for inviting me to testify before you today on the value of mammography screening in the early detection of breast cancer.

I am director of breast imaging and professor of radiology at the University of Cincinnati Medical Center, and am representing the American Cancer Society here today. I am also associated with the American College of Radiology, the Radiologic Society of North America, the American Roentgen Ray Society and the Association of University Radiologists.

As you have heard, there will be approximately 130,000 new cases of breast cancer and 41,000 women will die of breast cancer this year. The Office of Technology Assessment estimates that there will be 47,000 deaths from breast cancer this year. In 1965, there were 26,000 breast cancer deaths, and in 1975 there were 33,000 breast cancer deaths. Additionally, 1 in 10 women will develop the disease in their lifetime.

The use of screening mammography in conjunction with clinical examinations and breast self-examination can enable us to detect many breast cancers at their earliest stage, making these women candidates for much less arduous treatment.

As an example, in the OTA's presentation, for women over the age of 60, we have actually recently measured the stages in cancers that were detected among a population of women age 60 and older during the period that we screened, this same population whose cancers were then subsequently detected after screening was completed, and another group of patients who were referred to us in consultation. During the period of screening, only 18 percent of the cancers were stage 2 and higher—very advanced disease—and 29 percent of the cases were stage zero, and this is in older women while in the postscreening period, and in the women who had been referred to us independently, 48 to 50 percent of cancers were stage 2 and higher.

Another aside is in the group of women who were age 60, of the 21 cancers in the small population of women that were found during the screening period, only one woman has died in the past 14 years.

Chairman **Stark**. State that again.

Dr. **Moskowitz**. In other words, during the period in which the group of 1,200 women came in for screening—it was only offered for 4 years—there were 21 cancers found in that population. We have followed them all. Only 1 has died. Since that time—after screening—35 cancers have developed in that same population. Seven have already died.

Of more importance than the fact that they are detected earlier, is that carefully controlled scientific trials performed in the United

States and Sweden clearly indicate that mortality from breast cancer can be reduced by about 30 percent in populations of screened women age 40 and older.

The American Cancer Society believes that the reliability of mammography as a screening tool has been adequately demonstrated by scientific studies including the results of Health Insurance Plan of New York, the breast cancer detection demonstration projects cosponsored by the National Cancer Institute and the American Cancer Society as well as other major international studies in Sweden, Holland, and Italy.

I must emphasize that although treatment for breast cancer has changed resulting in much less deformity, the only chance to improve survival and reduce mortality is by screening and earlier detection. Therefore, given our current therapy and lack of primary prevention techniques, our only hope of stabilizing or reducing the number of breast cancer deaths is by mass screening.

Mammography is a low-dose x ray of the breast which can find many cancers about 2 to 4 years before they can be felt even by the most experienced examiner. The image receptor now used for screening is either film screen or xeromammography and both of these techniques, properly performed, can provide good images of x ray doses of one-fifth to one-half rad absorbed dose for two views of each breast.

During the mid-1970s, several studies were publicized which linked radiation exposure and breast cancer, leading people to question the value of screening. The source of radiation in these studies produced levels of exposure several orders of magnitude higher than those found in mammography, however.

Since that time, reevaluation of the data by age at initial exposure indicated that the risk in the high dose studies was essentially limited to younger women, not to the age group in question for screening. The World Health Organization Committee on Breast Imaging Technologies concluded that the radiation risk associated with modern screening is negligible.

The American Cancer Society and the American College of Radiology and the National Cancer Institute have all developed medical guidelines designed to promote early detection of breast cancer. For breast cancer, all three organizations have endorsed an annual mammography for asymptomatic women over age 50; for women age 40 to 49, all recommend a mammography every 1 to 2 years depending on physical mammographic findings and other risk factors. There is growing evidence that annual screening for this younger age group may be more appropriate.

One of the major barriers for screening mammography is the cost. The fees for diagnostic mammography as you have heard have ranged from $59 to $250. However, in the screening situation, operating costs and therefore patient charges can be dramatically reduced by the following measures.

One, operation in a low-overhead site close to where women work. Two, maintenance of a high volume of screenings, over 20 to 30 per day. Three, no onsite developing. Four, batch reading of film at the home base for lower unit charge. Five, utilization of simple computer programs to maintain a data base, generate reports and assist with patient followup. Six, payment requested at the time the procedure is performed to reduce billing costs. And seven, utilization of volunteers wherever possible. A mobile van, if operated appropriately, can bring these services to working women, convents, PTAs, et cetera.

In Cincinnati, the fees for screening mammography at 11 sites, operating independently, range from $33.50 to $55. This has been in place since November 1985.

Health insurers, as a rule, do not cover routine, preventive-care exams, like screening mammography. This is short-sighted, and many carriers are beginning to agree.

Blue Cross/Blue Shield of Southwest Ohio write coverage for mammography screening and, indeed, we just completed screening their asymptomatic women employees. Not only are the medical costs for treating advanced cancer more than those of treating early cancer, but other hidden costs are often neglected. The cost of short-term and long-term disability, and cost of replacing the dead and dying women in the workplace is often ignored.

Based on the Health Insurance Plan of New York study, using current direct costs for screening as well as induced costs, and accounting for the other cited costs for nonscreened women, I have estimated that there is a net gain to the system of about $1,500,000. Another way to look at these figures is that the cost of each death not averted because screening was not performed would be about $151,000.

Allowing for the cost of screening, the net savings per death averted is about $75,000 to $80,000. I have included a reprint of the article used to derive these figures in the packet before you.

While these data are not applicable to the Medicare population as they are not working directly in the workplace, they cannot be ignored. Further, in another part of the OTA assessment, their evaluation was that part of the induced costs of screening would be due to excess number of biopsies. This is not so for older women. Based on the the breast cancer detection demonstration projects, the ratio of biopsy false-positives to true positive rates is the same as in the general population and if these women are not detected when they are screened, the biopsy cost will be engendered after screening or in the absence of screening. Therefore, these do not, in this age, represent an added cost for the system.

At a workshop sponsored by the American Cancer Society on July 16–18, 1986, in Annapolis, Md., medical professionals, insurance representatives, and representatives from industry from all over the country got together to discuss strategies for lowering the cost of screening mammography. Many of these ideas have been touched on in the above comments. A copy of the papers presented at that meeting has been made available to you.

In closing, Mr. Chairman, I would commend the committee for its farsightedness in dealing with the issue of disease prevention, specifically as it relates to breast cancer. We heard earlier about Medicaid to pay for routine medical procedures.

I urge you to pass such legislation, and to expand the scope of this to require all third-party providers to do the same. Thank you.

I would ask that my written statement be included for the record, as well as other materials which you have before you. I will be happy to answer any questions you may have.

[The statement of Dr. Moskowitz follows:]

AMERICAN
CANCER
SOCIETY®

TESTIMONY OF

MYRON MOSKOWITZ, M.D.

DIRECTOR OF BREAST IMAGING
PROFESSOR OF RADIOLOGY
UNIVERSITY OF CINCINNATI MEDICAL CENTER
CINCINNATTI, OHIO

ON BEHALF OF

THE AMERICAN CANCER SOCIETY

REGARDING THE USE OF
SCREENING MAMMOGRAPHY
IN THE EARLY DETECTION OF BREAST CANCER

BEFORE THE HEALTH SUBCOMMITTEE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

NOVEMBER 3, 1987

For more information:
American Cancer Society
Kerrie B. Wilson
224 East Capitol Street
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Mr. Chairman, and Members of the Committee, thank you for inviting me to testify before you today on the value of mammography screening in the early detection of breast cancer. This is a timely issue; two weeks ago Mrs. Nancy Reagan became a statistic -- one of the 130,000 women in 1987 who will be diagnosed with breast cancer. But the fact that her cancer was detected through mammography at an early stage make the prognosis for her recovery and survival very good indeed.

I am Director of Breast Imaging and Professor of Radiology at the University of Cincinnati Medical Center, and am representing the American Cancer Society here today. I am also associated with the American College of Radiology, the Radiologic Society of North America, the American Roentgen Ray Society and the Association of University Radiologists.

According to the American Cancer Society's 1987 Cancer Facts and Figures, there will be approximately 130,000 new cases of breast cancer and 41,000 women will die of breast cancer this year. This is the first time that breast cancer deaths have climbed into the 40,000 deaths per year range, having hovered in the mid 30's for many years. Additionally, one out of every ten women will develop the disease in their lifetime. Appropriate use of screening mammography, in conjunction with clinical examination and breast self examination (BSE), can enable us to detect many breast cancers at their earliest stage, making these women candidates for much less arduous treatment, and increasing the chances for long term survival by as much as 40 percent.

I must emphasize that, although treatment for breast cancer has changed, resulting in much less deformity, the only chance to improve survival and reduce mortality is by screening and earlier detection.

Mammography is a low dose x-ray of the breast which can find many breast cancers about two to four years before they can be felt by even the most experienced examiner. The image receptors now used for most screening mammograms are either film/screen or xeromammography (a technique similar to that of a copier machine). Both of these techniques, if properly performed, can provide good images with x-ray doses of 1/5 to 1/2 rad absorbed dose for two views of each breast. During the mid-1970's several studies were publicized which linked radiation exposure and breast cancer, leading people to question the value of screening. The source of radiation in these studies produced levels of exposure several orders of magnitude higher than those found in mammography, however. Since that time, re-evaulation of the data by age at initial exposure indicated that the risk in the high dose studies was essentially limted to younger women, not to the age group in question for screening. The World Health Organization Committee on Breast Imaging Technologies concluded that the radiation risk associated with modern screening is negligible.

Of most importance is that carefully controlled, scientific trials performed in the United States and Sweden clearly indicate that deaths from breast cancer are reduced by about 30% in populations of women screened, age 40 and older.

As a screening measure, mammography will detect many very small localized breast cancers in women 35 years and older. Finding the cancer in the non-invasive state, before it spreads, means that in almost 100 percent of cases and with proper treatment the patient will remain free of the disease. In the Cincinnati Breast Cancer Detection Demonstration Project, the ten year survival for all breast cancers occurring during screening in women age 35-49 was 93 percent.

In older women, only one person whose cancer was found during the incidence years of screening has died since 1973. On the other hand, seven women whose cancers occurred in the post screening period have already passed away.

The American Cancer Society believes that the reliablity of mammography as a screening tool has been adequately demonstrated by scientific studies, including the results of the Health Insurance Plan (HIP) of New York, the Breast Cancer Detection Demonstration Projects (BCDDP), co-sponsored by the National Cancer Institute and the American Cancer Society, as well as other major international studies in Sweden, Holland, and Italy.

Recent data from the Breast Cancer Detection Demonstration Projects (BCDDP) indicate that nonpalpable breast cancers can be discovered by screening mammography at an earlier age than previously considered possible. The study offered annual mammography, physical examination, and BSE training to 280,000 women between the ages of 35 and 74 for five years. One-third of the 3,557 cancers detected in the project were minimal cancers. More than 75 percent of all cancers detected showed no evidence of lymph node involvement. Physician examination and mammography both contributed cases not detected by the other. The role of mammography was significantly greater; mammography alone found 40 percent of the cancers, compared with 10 percent found by physical examination alone. The relative contribution of mammography alone was impressively high for minimal cancers, and nearly 53 percent for infiltrating cancers less than one centimeter. The BCDDP, using newer mammographic technology, showed that mammography alone found cancers in women age 40-49 at about twice the rate than the HIP study had.

The American Cancer Society (ACS), the American College of Radiology (ACR), and the National Cancer Institute (NCI) have all developed medical guidelines designed to promote early detection of cancer. For breast cancer, all three organizations have endorsed an annual mammogram for asymptomatic women over age 50, and for women ages 40-49, all recommend a mammogram every one to two years, depending on physical/mammographic findings and other risk factors. There is growing evidence that annual screening for this age group may be more appropriate. In addition the American Cancer Society recommends a baseline mammogram for women between the ages of 35 and 39. Regular (monthly) breast self examination and clinical examination, beginning at an early age, are also important components of these early detection guidelines.

A recent study sponsored by the American Cancer Society and designed and analyzed by The Gallup Organization and Lieberman Research, Inc. "Women's Awareness and Use of Mammograms," found that while 83 percent of women age 40 and over have heard of mammograms, only 43 percent report that they have ever had one. As could be expected, the study found that higher income and better educated women are more familiar with mammograms than lower income and less educated women. Similarly, higher income and better educated women are more apt to have had mammograms than lower income and less educated women. The study found that only 35 percent of women surveyed said that their physicians had recommended a mammogram to them, but 94 percent of those whose physicians recommended the procedure complied. Physicians' recommendations play an important part in determining whether women have mammograms, as does education and income.

This sheds light on, perhaps, the biggest question -- what are the barriers to receiving the benefits of early detection of breast cancer through screening mammography? The reasons seem to be related to women's awareness of the benefits, the availability, and the cost of the procedure. These are key issues in disease prevention and health promotion, and the organizations I mentioned earlier, the American Cancer Society, The American College of Radiology, the National Cancer Institute, and numerous other health organizations, have developed excellent educational and service-oriented programs for physicians and the public to teach them about the value of early detection.

We are beginning to address the problems of cost of screening mammography. The fees for diagnostic mammography in the past have ranged from $95-$250. However, operating costs and, therefore, patient charges can be dramatically reduced by the following measures: 1) operation in a low overhead site close to where women live and work; 2) maintenance of a high volume of screenees (over 20-30 per day); 3) no on-site developing; 4) films are batch read by a radiologist at the home base for a lower unit charge; 5) utilization of simple computer programs to maintain a database, generate reports, and assist with patient follow up; and 6) utilization of volunteers wherever possible. A mobile van, if operated appropriately, can bring these services to working women, convents, PTA's, etc. When these operating parameters are followed, patient fees range from $27-$55 per screening exam, including interpretation. In Cincinnati the fees for screening mammography at eleven sites, operating independently, range from $33.50-$55.00. Consultative breast imaging is in the $100 range.

Why then, don't more physicians recommend the screening mammography procedure? Many doctors will not recommend the procedure for their asymptomatic patients if it is not covered by insurance. Health insurers, as a rule, do not cover routine, preventive-care exams, like screening mammography. This is short sighted, and many carriers are beginning to agree.

Blue Cross/Blue Shield of Southwest Ohio write coverage for mammography screening and, indeed, we just completed screening their asymptomatic women employees. Not only are the medical costs for treating advanced cancer more than those of treating early cancer, but other hidden costs are often neglected. The cost of short term and long term disability, and cost of replacing the dead and dying women in the workplace is often ignored. Based on the Health Insurance Plan of New York study, using current direct costs for screening as well as induced costs, and accounting for the other cited costs for nonscreened women, there is a net gain to the system of about $1,500,000. Another way to look at these figures is that the cost of each death not averted because screening was not performed would be about $151,000.

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At a workshop sponsored by the American Cancer Society on July 16-18, 1986, in Annapolis, Maryland, medical professionals, insurance representatives, and representatives from industry from all over the country got together to discuss strategies for lowering the cost of screening mammography. Many of these ideas have been touched on in the above comments. A copy of the papers presented at that meeting has been made available to you.

In closing, Mr. Chairman, I would commend the Committee for its farsightedness in dealing with the issue of disease prevention, specifically as it relates to breast cancer. I understand that several bills introduced in the U.S. Congress would require Medicare to pay for routine, preventive medical procedures. I urge you to pass such legislation, and to expand the scope of this to require all third-party providers to do the same. Thank you. I would ask that my written statement be included for the record, as well as other materials which you have before you. I will be happy to answer any questions you may have.

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# Costs of Screening for Breast Cancer

*Myron Moskowitz, M.D.**

Breast cancer remains a major cause of cancer mortality in women despite changes in surgical technique and advances in chemotherapy. Controlled population based trials in Sweden[32] and the United States,[34] and case control studies in Holland[6, 32] have clearly demonstrated that when mammographic screening is offered to populations of women 40 years of age and older, an overall 30–35 per cent mortality reduction can be expected. Closer analysis of the subgroups within the population of women offered screening indicates that mortality reduction occurred within 3.5 years after entry in the women 50 years of age and older. Long-term follow-up of the American trial, at eighteen years, indicates that a mortality reduction occurs in the younger women, but its appearance was delayed until seven years after entry.[27, 35] Habbema, et al,[13] in a detailed analysis of the Health Insurance Plan of New York (HIP) data confirm that there was no evidence to suggest an age specific mortality reduction by screening. In fact, after correction for cancer cases by age, the greatest per cent mortality reduction was seen in women age 40–44 at entry.

## WHY WAS NO EARLY BENEFIT DEMONSTRATED IN YOUNGER WOMEN IN THE CONTROLLED TRIALS?

In the HIP trial in the 1960s in New York City, mammography and clinical examination were performed annually. Screen threshold sensitivity for size was rather high, with a very low yield of minimal breast cancer as compared to the control group. Further, less than 20 per cent of the cancers in younger women were found by mammography alone. In contrast, over 40 per cent of the cases in older women were found by mammography alone. In the Breast Cancer Detection Demonstration Project (BCDDP), about 40 per cent of cancers were found by mammography alone in all ages.[1]

Data generated from the Cincinnati BCDDP strongly suggest that the lead time gained by screening younger women (using both clinical examination and mammography) is about two years, plus or minus a half year. For older women it is about four years, plus or minus a half year.[30]

If the interval between screens is too long, and if clinical examination is important particularly in younger women, but is omitted, then one would expect an excess number of cases to occur between screens and to be unaffected by the screens. In the Swedish trial and the Dutch study, only mammography was performed, and for younger women intervals of 2.0 to 2.5 years between screenings were the mode. For older women screening was performed every 3.0 to 3.5 years.[32]

The Dutch data clearly indicate that there are twice as many interval cancers in younger women as there are in older women in their study, and about four times as many as in the Cincinnati screen where clinical examination and annual screening were the mode.[6, 30, 34] The data have not yet been reported from the Swedish trial and, therefore, are only cause for speculation at this point. Nevertheless, there is no reason to believe that they will not follow closely upon the results of the Dutch trial.

These results strongly suggest that, in the extant controlled trials, screen sensitivity was iatrogenically blunted.

The data also suggest that for populations of women over the age of 50, biennial screening with mammography, and possibly without clinical examination, is certainly rational. In fact this strategy is currently being recommended by the Swedish National Board of Health and Welfare.[12]

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*Director, Breast Imaging, Breast Consultation Center, and Professor of Radiology, Department of Radiology, University of Cincinnati Medical Center, Cincinnati, OH

## SHOULD WOMEN AGE 40–49 BE SCREENED AND, IF SO, AT WHAT INTERVALS?

The HIP study has shown that even an insensitive screen performed at annual intervals can produce a delayed reduction in breast cancer mortality. Based on our data from the Cincinnati BCDDP, it seems that a more sensitive screen performed at annual intervals may produce a greater overall benefit and may produce it at an earlier point in time.[20] If women age 40–49 are to be screened, I believe annual examination with mammography and clinical examination is the most rational approach. Again, the Swedish National Board of Health and Welfare suggests that women begin screening at age 40 and that it be done at intervals not to exceed 18 months.

The only reasons not to screen large populations of women would be related to radiation risks and costs. Given the low dose at which mammograms can be obtained today, and assuming that there will be some rational quality control observed, risk, according to the World Health Organization, "is negligible" for women in the age group of 40 and older.[18]

## WHAT ABOUT COSTS?

Cost benefit evaluations are perhaps among the trickiest estimations and possibly among the least reliable estimations that we are called upon to make in medicine. In the area of breast cancer screening there are some particularly difficult decisions that one must face. To begin, one must determine the appropriate parameter for evaluation. Does one evaluate the cost of mammographic and clinical screening versus no screening? Or does one evaluate the added cost of mammographic screening? If one opts for the latter, it would seem that the question is incompletely posed for the following reason: the question presumes there is no added cost for clinical examination screening other than what currently exists in the health care system, and it further assumes there is a benefit to clinical screening that can be clearly dissected from mammographic screening. Each assumption is incorrect.

There has never been any evidence from any controlled trial that clinical examination alone, as a screening tool, has an impact on mortality. On the other hand, there is clear evidence that combined screening is effective in mortality reduction in women over age 39. There is also clear evidence that mammographic screening as the sole modality of screening is effective in women age 50 years and above.

The assumption that there will be no added cost to the system for doing only clinical examination screening is pernicious. Implicit in this thought is either that large numbers of women are being screened now by clinical exam, or that clinical screening will be cheaper to perform than mammography screening.

The former is simply not the case. To assume that this extra crush of well women who will need to be screened can be handled in physicians' offices is naive. Physicians are already overburdened with providing care for their ill patients, and this load would tax the system to the extreme.

Considering that mammographic screening is being performed at fees ranging as low as $27 per examination and that fees of $40–$50 are very common,[17] it seems unlikely that clinical exam fees will be much cheaper if screening is carried out in physicians' offices. It may be that screening can be performed equally well by paraclinical people, such as nurses, but this does not guarantee cheaper fees to the screenees.

We have previously found[22] that a major portion of the costs associated with screening are the daily costs of operating a facility, including maintaining a database. While the costs per mammogram are still more than clinical costs, the unit differential, if each were performed alone, is not as great as might have been expected. Further, when one takes into account the fact that the false-positive call rate for physical exam is twice that associated with mammography,[5, 21] the cost differential is quickly consumed.

Therefore, in my opinion, if the costs of screening are to be determined and compared to the *existing nonscreening* system, the best comparison is total independent costs for clinical as well as mammographic screening, and the combined costs of both modalities performed together.

When there is an effective, safe technology that can definitely reduce mortality, one has to be extremely cautious about eliminating it as an utilitarian tool because of what may be perceived by some as excess cost. The human condition being what it is, costs in the abstract perhaps can be objectively discussed. Costs for averting death seem to take on an entirely different dimension when the individual evaluating the question, or his loved ones, are directly affected.

## COST–BENEFIT ANALYSIS

For this particular analysis of cost–benefit, I have chosen to use the published information from the HIP study and apply to it a $45 screening fee. This includes the entire mammographic component and a $5 clinical examination by a nurse palpator. These fees are not out of line with what others have reported,[12, 13] and are the extant screening fees in Cincinnati.

It must be remembered that the HIP study was planned to offer an initial, or prevalence, screening examination and three subsequent yearly screening examinations to each of 30,000 study women. What is remarkable is that of the projected 120,000 screens expected, only 65,000 screens were actually done and, still, the 30 per cent mortality reduction in the whole population was achieved.[29] As can be seen in Table 1, at $45 per examination the total cost directly attributable to the screening itself was $2,925,000. We have added an additional cost of $312,000 to account for time off work that women may have taken to attend the screening process,* for a total four-year direct cost of $3,237,000.

There were 290 cancers that occurred in the entire population offered screening. Sixty per cent were found as a result of screening; some were missed, and many occurred in the subpopulation of 10,000 women who did not attend even one round of screening.

In addition to the costs that are directly attributable to the screen itself, there are also induced costs. In the course of screening, a certain number of false-positive calls will occur. One can expect that there will be more of them than would occur in the course of usual case finding. These will require additional workup to establish a diagnosis. Some of these will require excisional biopsy; some only ultrasound or needle aspiration; some only short-term follow-up to determine if they regress in response to hormonal flux.

In a previous work, based on local data, the cost per biopsy performed was estimated to be about $475.[22] Scitovsky and McCall in 1976[24] estimated that a surgeon's fee for needle biopsy was $25, and for excisional biopsy, $150. Hospital costs for outpatient and inpatient biopsy were estimated by them to be $100 and $500, respectively, based on the data of Hunt and Crass as referenced in Scitovsky and McCall.[24] Thus, the cost for biopsy would range from $125–$650. It should be noted that today, in Cincinnati, it is extremely unusual for breast biopsies to be performed on an inpatient basis.

Table 1. *Screened Costs**

| | |
|---|---|
| Women screened at $45 for 4 yrs | $2,925,000 |
| Time off for each woman screened for 4 years | $ 312,000 |
| Total 4-year cost | $3,237,000 |
| Induced costs for 174 cancers at $4800 per cancer | $ 835,200 |
| Total screen cost | $4,072,200 |

*Based on HIP, with 65,000 screens actually done out of 120,000 expected.

Today we estimate an induced cost of $8000 per cancer found by screening, which assumes ten diagnostic workups for false-positive calls for each cancer actually found. Because in the nonscreened population the biopsy to cancer yield ratio is about 4:1,[7, 21, 31] the *excess* induced cost per cancer found is $4800. In HIP study cases, only 60 per cent of the cases were found by the screen, so that the excess induced cost engendered by the screen would be $835,200. Thus, the total screening costs attributable to the HIP study with current expenses would be $4,072,200 (Table 1).

Additional costs engendered by screening include emotional trauma induced by false-positive diagnoses; the cost of false-negative screens with their attendant false reassurance, perhaps leading to delay in diagnosis; and the costs of time away from the workplace to attend screening. The costs of the first two are almost impossible to determine, and are common to *any* screening procedure. The third can be estimated, which we have done.

If the diagnostic workup can be completed within a short period of time, the duration of the fear factor is short-lived. The number of false-negative cases can be reduced significantly by use of clinical examination and mammography as tandem screening modalities.[19, 23]

Some would add the costs of primary treatment for cases detected at screening. We have not done so because this presupposes that most of the cases detected at screening would never present as clinical cancers in the course of usual case finding. This is a cherished concept, widely

---

*This calculation assumes an average annual salary of $20,000, 260 working days per year, and a half hour off for examination (on a mobile van parked at the worksite).

Table 2. *Costs for Nonscreened Group*

| | |
|---|---|
| Medical costs for treatment of 37 patients who eventually died of cancer | $2.220.000 |
| Short-term disability costs | $ 926.640 |
| Long-term disability costs | $1.710.720 |
| Replacement costs for these 37 women | $ 712.800 |
| Total cost | $5.570.160 |

held and nurtured, but not supported by any hard data. The data that are available from the BCDDP suggest that quite the converse is true (vide infra). While some of these cancers may present at some time in the future, the mean detection lead time that can be gained by current screening is about two years for women 40–49. Because no significant number of excess cancers can be shown to exist in the screened population, simple arithmetic tells us that most of the screen-detected cancers would have presented well within the lifetime of the cohort had screening not been done.

For older women there may be subclinical cases that would not present clinically due to competing causes of death. Because there is no evidence that subclinical cancer is not cancer, I consider it to be so. I can see no reason to wait until the disease is incurable before attempting to cure it. Therefore, there would be no additional primary treatment costs for screening.

There are, however, costs for *not* screening that must be considered. There were 37 patients in the HIP trial whose deaths were averted as a result of screening. If unscreened, the treatment costs attributable to these 37 patients at $60.000 per case would be $2,220,000. Additionally, other costs that must be considered, particularly by industry, are the costs borne for short-term disability and long-term disability. Based on the information provided by Schwartz and Rollins,[26] the short-term and long-term disability costs to industry for these 37 women are $2.637,360. Replacement costs for these 37 women in their positions, again according to Schwartz and Rollins, would be $712,800. The total cost for *not* screening, therefore, would be $5,570,160 (Table 2).

Therefore, as can be seen in Table 3, the net effect on a health care system engendered by the HIP study, using current costs, is a gain of about $1,497,960. This represents a cost effectiveness ratio of 0.73.

Table 3. *Cost-Effectiveness-Benefit**

| | |
|---|---|
| Cost-effectiveness ratio | 0.73 |
| Cost per cancer found | $ 23.403 |
| Cost per death averted | $123.400 |

*HIP

As Weinstein and Stason point out,[33] there is a difference between a cost-benefit analysis and cost-effective evaluation. For the former it is necessary to define a benefit and assign to it a cost. Thus, one can, for example, estimate the cost per death averted, cost per cancer found, or cost per year of life added. This is mostly useful in allowing a comparison between the cost for the system under investigation and other costs in the health care system. However, using it requires that one set a dollar value on human life, pain and/or suffering.

A cost-effective analysis determines the total costs for a given intervention and allows comparison with the costs of no intervention. When the ratio of the cost of the intervention to the nonintervention is less than one, it is clearly cost effective.

From our cost-effective analysis it appears that it is cheaper to screen than not to screen. However, one cost that we did not consider has been pointed out by Weinstein and Stason.[33] They suggest that the cost that may be incurred by the women survivors who may subsequently contract other diseases or even die of them is a legitimate cost to the treatment (screening) modality. This argument is inexhaustible and, philosophically, difficult to justify. If carried to its extreme, it would lead us to abandon all medical care. This would be the ultimate cost-effective strategy.

Using the costs engendered by the screening process and the associated induced costs, the cost per cancer actually found in HIP was $23.403 (Table 3). Using Habbema's estimates, the cost per person year saved in HIP would be $3770.56.

Alternative models can be considered in order to evaluate the relative cost–benefit of clinical and mammographic screening. Again, these must be recognized as models for which proof is lacking.

I propose such a model based upon data from two BCDDP's (Cincinnati and Milwaukee), and a benefit risk model previously published.[9] This cost–benefit analysis projects the effects of a five-year screen on populations of 100,000 randomly selected, asymptomatic women and is estimated by age at entry. The model assumes a correction for 20 per cent interval rate, corrections for self selection and prevalence as seen in the BCDDP, a sojourn time of about ten years (as opposed to lead time), and a correction is made for deaths theoretically induced by one rad per year due to mammogra-

Table 4. *Cost–Benefit Analysis for Screening by Age Cohort 100,000 Asymptomatic, Randomly Selected Women for Five Years**

| MODALITY | AGE AT START | TOTAL COST** | CANCERS FOUND | COST PER CANCER FOUND | NET DEATHS AVERTED† | COST PER NET ADDED DEATH AVERTED |
|---|---|---|---|---|---|---|
| Physical exam | 40 | $ 9.2 × $10^6$ | 170 | $50.0 × $10^3$ | 62 | $150 × $10^3$ |
| | 50 | $12.5 × $10^6$ | 515 | $20.0 × $10^3$ | 128 | $100 × $10^3$ |
| | 60 | $14.5 × $10^6$ | 723 | $20.0 × $10^3$ | 111 | $130 × $10^3$ |
| Mammography alone | 40 | $ 9.3 × $10^6$ | 344 | $27.0 × $10^3$ | 86 | $110 × $10^3$ |
| | 50 | $ 9.8 × $10^6$ | 457 | $21.0 × $10^3$ | 129 | $ 80 × $10^3$ |
| | 60 | $11.4 × $10^6$ | 783 | $15.0 × $10^3$ | 193 | $ 60 × $10^3$ |
| Physical exam and mammography | 40 | $12.5 × $10^6$ | 514 | $24.0 × $10^3$ | 148 | $ 80 × $10^3$ |
| | 50 | $16.9 × $10^6$ | 972 | $17.0 × $10^3$ | 257 | $ 70 × $10^3$ |
| | 60 | $22.1 × $10^6$ | 1506 | $15.0 × $10^3$ | 304 | $ 70 × $10^3$ |

*Deaths averted at 20 years. Model based on benefit/risk model by Fox and Moskowitz.[9]

**Assumes two-thirds offered screening accepted. See text for cost assumption.

†Deaths due to the assumed risk of mammography and deaths averted if not screened have been subtracted.

phy. This latter correction is now an overestimate of about tenfold due to decrease in mammographic radiation exposure.

The cost assumptions are as follows: (1) two-thirds of women offered screening will accept it without loss of efficacy of the screening process; (2) mammographic charges are $22 per exam, common costs are $18 per exam, physical examination costs are $5 per exam. Therefore, each clinical exam will cost $23, and each mammography exam will be $40. If done together, the charge for the whole screen will be $45; (3) the induced cost above baseline induced costs for mammography will be $4800 per cancer found, and the induced costs above baseline for clinical or combined screening will be $9600 for each cancer found. This is due to the high rate of false-positive calls on clinical exam screening.

The model assumes that only two-thirds of the cancers present in the five-year period of screening will be detected by screening, due to both interval rate and incomplete attendance of the cohort. The deaths averted were based on stage at detection by the given modalities. This model estimates a 38 per cent mortality reduction at 20 years for a combined screen for younger women. A 30 per cent reduction was shown by the HIP trial in this same period.

As shown in Table 4, there will undoubtedly be excess costs above the current nonsystem of nonscreening, no matter which approach is used to screen. Younger women are more costly to salvage than older women, and this is true whether screening is done with mammography alone or clinical exam alone. For women age 40–49, however, the cost per death averted at 20 years is more for clinical exam than mammography (approximately $150,000:$110,000 per death averted). At no age is clinical exam alone more cost effective.

Using Habbema's estimates for life years saved, the cost per life year saved for younger women would be $2500. For women 50–54 it rises to $3800, and for women 60–64 the cost would rise to $6300 (Table 5).

It therefore seems that the most cost beneficial approach to screening would be combined examination at almost all ages. Under ideal circumstances this would be offered at the screening site, and would best be handled by trained paraclinical examiners. If physician fees for clinical screening could be brought to a $5–$10 charge per exam, it might be preferable to have clinicians performing this exam. This fee structure has already been achieved for screening mammography.[17, 30] I am not certain that the same economies of scale and effort can be achieved with clinical exam.

If the costs for not screening are considered, the actual cost for each death not averted would be $151,270. Therefore, one could argue that at all ages, money is saved by offering screen-

Table 5. *Combined Screening—Age-Specific Estimated Cost Per Person Year Saved for Populations of 100,000 Women*

| | TOTAL COST | LIFE YEARS SAVED* | COST PER PERSON YEAR |
|---|---|---|---|
| 40–44 | $12.5 × $10^6$ | 5100 | $2500 |
| 50–54 | $16.9 × $10^6$ | 4400 | $3800 |
| 60–64 | $22.1 × $10^6$ | 3500 | $6300 |

*After Habbema JDF, van Oortmarssen GJ, van Putten DJ, et al: Age-specific reduction in breast cancer mortality by screening: An analysis of the results of the Health Insurance Plan of Greater New York study. JNCI 77(2):317, 1986.

ing. For combined screening the savings per death averted are $70,000–$80,000.

It should be noted that the cost per case found by modality ranges from $15,000–$50,000, the most expensive modality being clinical exam for the ages 40–49.

One might argue that this model underestimates expense because it does not include costs for the whole population offered screening. If one did charge this to the whole population, the assumption is that because all women will be offered screening, it must be assumed that all will accept it. The counter to that argument is that if that were the case, it is possible that the benefit of combined screening would be correspondingly greater. There is no evidence to support either side in this case. The data used were the best data available and, I believe, reduce speculation to a minimum.

## WHAT CAN THESE COSTS BE COMPARED TO IN THE CURRENT MEDICAL SYSTEM?

It has been recently estimated that the cost per cervical cancer detected is $17,000. Renal dialysis costs have been estimated to run between $23,000 and $32,000 per year; the first year of coronary bypass surgery has been estimated at $13,500. It has been estimated that the cost per day for the last month of life of a terminal cancer patient ranges around $1200–$1500.[4, 5, 10, 14, 15, 16, 23, 33] The cost for cardiac and hepatic transplant and the use of artificial hearts will not be considered here.

We have not yet considered the costs of the newer diagnostic technologies that are gaining widespread acceptance, such as magnetic resonance imaging, or even computed tomography. This is not to denigrate their use nor their importance in patient management, but on a unit basis, considering the capital expenditures, technology, and professional fees involved, it is doubtful that they would compare more favorably, costwise, than traditional screening for breast cancer.

Gravelle and coworkers[11] have estimated the added costs to the British National Health System if widespread screening were introduced. They estimate the cost per true-positive varied depending on examiner and the screening strategies employed. The costs ranged from £2742 (sterling) to a high of £4552. Cost per woman year of life saved was estimated to run from £819 to £1359. Scitovsky and McCall[24] estimated that in the United States in terms of 1973 data the yearly mortality cost of breast cancer was $998,004,723. They also estimate that in 1975 the total indirect cost of breast cancer due to mortality and morbidity was a little over one billion dollars. This does not include medical care costs. This calculates out to $32,250 lost for each woman who died of breast cancer that year.

## TO WHOM ARE THESE DIFFERENT STRATEGIES IMPORTANT?

To a health maintenance organization, total costs may be the primary concern; to a group practice affiliated with a separate fiscal intermediary, nonreimbursable costs may be of paramount interest.[35] To an industry that provides disability protection as well as medical care costs as part of its employee benefit package, cost-effective analyses such as we have provided may be most important.

Last to be considered in these pecuniary analyses is the individual. An individual generally is concerned primarily with those expenses that reduce discretionary income. If she perceives that the cost is not excessive compared to the expected gain, it is probable that she will opt for the procedure. It is difficult to predict what women will perceive as a reasonable fee for screening. After all, people play the lottery every day and the odds against any major gain are staggering.

## SUMMARY

A cost–benefit analysis clearly shows that the costs for screening a large population of asymptomatic women are well within the cost–benefit range that is accepted for other areas within the medical care system. If profit and loss were the only considerations, one would opt for screening with combined examination for all women age 40 and older. If medical and philosophical considerations were to be included in the equation, clinical examination alone at any age cannot be justified. However, one might be able to justify mammography screening.

Bierman has stated, "ultimately, when the scent is of flesh rather than figures, even the economist concedes that it will be important to insulate the individual practitioner (from cost–benefit/cost–effectiveness analysis) on a day-to-day basis because of potential conflict with the commitment to do what is best for each patient. Here is the crux. The economist's reference to the 'nation's health' is at best ambiguous and more likely meaningless. The physician's commitment to the patient's health is neither of these: it is clear, undeniable, and profoundly meaningful."[2]

Reduction in cancer deaths is not easy to come by. When a method is available that can achieve this result, every effort should be made to make it available until it can be replaced satisfactorily by a less expensive, equally effective modality.

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Chairman STARK. Thank you very much. Your statement will appear in the record. I have two questions. Does the $50 fee we talked about today seem a ball park figure?

Dr. MOSKOWITZ. Yes. As a matter of fact we at the University of Cincinnati, I can tell you exactly what our fees are. We offer screening at a fixed site for $40 and that includes a professional interpretation fee of $10; and a clinical examination by a nurse palpatator—a trained woman who has done over 50,000 examinations; trained by us—for $5, although the university did just add a $2.50 parking fee.

But on our van we only charge $40 for the mammography screening.

Chairman STARK. All right. The other question—you are the only one who has ventured to say you would spot some long-term savings and in your testimony you talk about death costs. Where do you and the other estimators differ? Is there a difference here that I am missing?

Dr. MOSKOWITZ. I am aware of Dr. Eddie's model and I have "plugged" a couple of figures into Eddie's model, and made some estimates for using his figures for younger woman. I have not done it for older women. He estimates $23,000 treatment and medical costs for each death averted.

That is low. I think Atlantic Richfield Corp. has a bottom line to consider as well. They estimate $60,000 for each death averted. I sort of plugged that figure in using his model and using our survey costs for younger women. It comes to $107,000 for each death diverted. For older women, since there are twice as many cancers, the net cost would probably be about $50,000.

What I have considered for younger women is the cost of replacing these people in the workplace. It costs $20,000. I think it is important.

There is also the cost of long-term, short-term disability which runs $60,000, $70,000, depending on whose figures you believe.

Chairman STARK. In the elderly population we can't use that, but that is what you are suggesting. You are estimating that the costs are significantly higher in the cost of a death for an elderly person. Would it make up for either disability cost or lost time cost?

Dr. MOSKOWITZ. I think David's estimate is too high because there is an excess induced cost estimate and not a big enough benefit estimate for deaths averted by avoiding late treatment.

Chairman STARK. I will ask one thing if you would care to at some time later submit information either just for my edification or for the record. One of the problems we have with OMB is structural rather than philosophical as I have often said facetiously. They know the cost and value of everything but we as a Congress get absolutely nothing. In other words, if we were to enter into a program like this in our elaborate budget deliberations, we would just get the costs, regardless of whether you and all the other experts in the country could agree how much we would save four or five years from now.

I think that as we proceed, this may prevent us in an empirical sense from doing what we know philosophically is the right thing to do and what experts tell us. We might very well cut out many good tests which would save many lives only because they won't save them in the year we pay for the tests, which seems ridiculous to me, but to make the kind of change we would have to make we need more reinforcement.

It is another issue, but any assistance or any of your articles you care to send out, we would appreciate. We run into it right here, but we run into it every day whether it is preventive surgery or preventive care for a diabetic with certain kinds of appliances that will prevent future surgery.

Dr. MOSKOWITZ. There are problems. I would cite you a chapter I have just written—it is in final draft—on breast cancer in the elderly. We are looking at the actual raw data. It is going to cost some money. It is going to cost an initial outlay and you are not going to recoup it until later, if you recoup it at all.

I am in an awkward position as a physician. I find myself now wearing a green eye shade and sitting on a high stool. The real problem here is that I should be evaluating the medical benefit. I find it interesting that someone said earlier that we only gain 268 days of life by screening. There aren't too many things we do in medicine where we gain one day of life. We have been spoiled by the discovery of penicillin 30 years ago because we could treat and cure pneumococcal pneumonia with penicillin. We all of a sudden believed we could do more.

It is very difficult for me to dismiss out of hand any additional time we can add to life as long as the cost is within reason.

[The following was subsequently received:]

UNIVERSITY OF CINCINNATI HOSPITAL,
BREAST CONSULTATION CENTER,
*Cincinnati, OH, November 10, 1987.*

Hon. FORTNEY H. STARK,
*Longworth House Office Building,*
*Washington, DC.*

DEAR CONGRESSMAN STARK: As you requested of me at my testimony last week before the House Ways and Means Committee, I am enclosing a copy of a manuscript which I have submitted which will appear as a chapter in a book entitled "Approaches to Early Detection and Treatment of Cancer in the Elderly." Feel free to use the information that I have presented there as you feel necessary.

The chapter has just been completed and has not yet seen print.

I am also enclosing for your information a reprint of an article about strategies of screening and age-specific natural history of the disease.

I hope this will be of help to you in your deliberations.

Very sincerely yours,

MYRON MOSKOWITZ, M.D., F.A.C.R.

Enclosures.

[The enclosures are being retained in the committee files.]

Chairman STARK. I share your thoughts. Thank you very much. I am going to call the last two witnesses to the witness table together. if I may, and ask Cynthia Pearson and Robert Maxwell, the vice president of the AARP, if they would both find their way to the witness table and ask Ms. Pearson if she would present her testimony.

Your prepared testimony will appear in the record in its entirety, and you may expand on it, summarize it, do whatever you like and when you are completed, if Mr. Maxwell would like to summarize or expand on his—we will save the best for last. Ms. Pearson, proceed.

## STATEMENT OF CYNTHIA A. PEARSON, PROGRAM DIRECTOR, NATIONAL WOMEN'S HEALTH NETWORK

Ms. PEARSON. Thank you for inviting us to testify today. The National Women's Health Network is a nonprofit organization devoted solely to women and health. As an advocacy organization, we see our organization as the appropriate group to raise concerns of our members, and to raise some issues about quality assurance if this bill is passed.

We urge this committee to vote favorably for the bill. We believe that women all over the country who are Medicare beneficiaries should receive coverage for mammogram screening when they are asymptomatic.

The committee right now has the opportunity to provide women with protections that are offered by early screening for and early detection of breast cancer and we think it is imperative every woman have the opportunity to have her cancer caught in an early stage just the way Nancy Reagan's was.

We would also like to ask the committee, in the event the bill is passed, the committee work with the implementing agency to make sure this measure includes quality mechanisms. We believe and we think you believe mammography cannot and should not be done by just anyone who owns x ray equipment nor should it be isolated from other prevention measures such as self-exam and dietary guidelines for lowering one's chances of cancer.

Both of these can be integrated into the programs you are considering reimbursing for. We believe they should be. They can play an invaluable role in saving women's lives. We, as you, don't want mammography mills. We want a total effort which teaches prevention and self-exam as well as providing quality x rays. We recently conducted an investigation of mammography services around the country.

We have preliminary results on 38 clinics in over 20 cities. We sought information on a variety of topics, and I would like to share three recommendations that we have for you based on the preliminary results of this survey. Price in our survey was not related to the amount of services offered. The highest priced clinic which, in our survey was $215, did not guarantee the most thorough or comprehensive service and the lowest price which in our survey was $37, was not at all the least comprehensive clinic.

We support the language in your bill setting reimbursement at $50 for the taking and reading of the mammogram. We also have a recommendation that the clinics who are approved for reimbursement under this bill be required to accept women who decide independently of a physician they want a mammogram.

Our experience with our members is that many women don't have a family doctor the way most of us did 20 or 30 years ago and they seek health care when they believe it is needed. For many women right now will be the time that they think they need a mammogram because of the publicity given in Nancy Reagan's case.

We think it is very important for facilities to allow women to refer themselves for screening and in our survey only half of the facilities did that.

Chairman **Stark**. We are thinking of suggesting to every Medicare approved hospital that they have to have a radiology department. Then we might as well just insist they do the test there.

Ms. **Pearson**. That would be great.

Chairman **Stark**. It would appear that it would be a way to make sure that they could go to any Medicare-approved hospital and get the test.

Ms. **Pearson**. I would be curious to hear the previous witness' opinion about that because he made a point of saying it was important to provide—to be able to provide mammograms for $50; it was important they be provided in low cost settings, and I am not—well, he is not in the room, but I know from past experience as a clinic administrator sometimes teaching hospitals aren't necessarily the most low cost.

Chairman **Stark**. Well, we try to compensate them in other ways so they can pay us back.

Ms. **Pearson**. I agree with you that would be an easy way to solve the problem of referrals.

Another recommendation that we have that you have already adopted in the language of the bill is to require that clinics store the records for an indefinite period of time. Many women are being encouraged to have base line mammograms up to 10 or 15 years before they might enter into routine screening processes—I think one out of every six clinics we surveyed did not keep the records indefinitely. So we see this as a problem that exists currently.

And then another recommendation that we would make which can be dealt with in the implementation stage is the issue of calibration of the equipment used and how often that is done. We believe the standards that reimbursed facilities use should be based on how often the machinery is used, not on a set amount of time. In our survey the set amount of time standard of calibrating the machines varied from once a day to once a year.

And then lastly, we would recommend that the implementation include a requirement that clinics providing screening mammographies include information for women on breast self-examination, which is frequently done but also on the role that a low fat diet can play in prevention and the National Cancer Institute has already prepared materials like this.

Chairman **Stark**. Have you had much help from the dairy council and beef council on that?

Ms. **Pearson**. Not what we wish, I guess. We are always very sensitive to the issue of not requiring necessarily extensive counseling that has to be done with a big input of staff time that would then make it impossible to live with that cap and make providers select out of the Medicare program.

But this information is so important and low fat diets seem to be the only known way to prevent cancer in the population of women as a whole, and since the materials have already been prepared we think they can easily be incorporated in a written form by any clinic that is applying for Medicare reimbursement for screening mammograms.

In summary, we think these implementation guidelines are inexpensive, simple, don't necessitate amending the bill in any way, but would improve the real bottom line which is saving women's lives from cancer.

[The statement of Ms. Pearson follows:]

NATIONAL WOMEN'S HEALTH NETWORK

MAMMOGRAPHY SCREENING TESTIMONY NOVEMBER 3, 1987
CYNTHIA A. PEARSON
PROGRAM DIRECTOR
NATIONAL WOMEN'S HEALTH NETWORK

Mr. Chairman, members of the Subcommittee, thank you for inviting us to testify today. The National Women's Health Network is the only national organization devoted solely to women and health and as such is greatly interested in early detection of breast cancer.

Nancy Reagan is alive and well. Her cancer was caught very early. She has terrific odds to survive the next five years. This good news is due to mammography - a diagnostic tool which has the power to save thousands of American women's lives. Unfortunately, it is often beyond their reach financially.

The National Women's Health Network strongly urges this committee to vote favorably for Representative Stark's bill requiring that Medicare cover mammography for asymptomatic women, Farm women in rural Missouri, retired telephone operators in South Philadelphia and older homemakers in San Mateo deserve the advantage of this technology which can save their lives. They should not be deprived of the benefits mammography offers. This committee has the opportunity to provide them the protections offered by early detection of breast cancer. It is imperative that everyone's cancer is caught in the early stage just the way Nancy Reagan's was caught.

The National Women's Health Network would also ask that this committee work with the implementing agency to ensure that this measure - underwriting routine screening for breast cancer - include quality mechanisms. Mammography cannot and should not be done by just anyone who owns x-ray equipment.

Nor should it be isolated from other breast cancer prevention measures such as breast self-examination (BSE) and the National Cancer Institute's dietary guidelines for lowering one's chances of cancer. Both techniques can easily be integrated in to mammography examination programs and should be since they both play an invaluable role in saving women's lives. None of us want mammography mills - we want to save women's lives. Therefore, a total effort, one that teaches prevention, self-exam, and provides quality x-rays, is what should be supported with our taxpayer's dollars.

In the last year, the National Women's Health Network has been carefully evaluating the various clinics around the country in which a woman can have mammography. Facilities providing mammograms can perform an outstanding service or they can be a profit center for radiologists' practices or debt-ridden hospitals. What sets apart a good facility is their attention to technical quality and education. This bill can help insure improved quality of mammography care for all.

The Network has recently conducted an investigation of mammography services around the country. We administered a survey on 38 clinics in over 20 cities. The survey sought information on a variety of topics: is the machine used only for mammography, what dosage is used, is the provider specifically trained in mammography, how often is the machine calibrated, what is the routine charge and what is included in that service. Our survey has uncovered some surprising and some distressing findings.

Price is not related to the services which are provided. Prices do vary from a low of $37 to a high of $215. The highest price did not guarantee the most thorough service and the lowest price wasn't charged by the worst clinic. We support the language of the bill which sets reimbursement at $50.

We found that many clinics do not accept women who decide independently of a physician that they want a mammogram. In our highly mobile society, many women and men do not have a personal physician. Health care is sought only when it is needed and then the appropriate physician, nurse practitioner or specialist is found. Similarly, physicians move away or retire. This means that for many the days of the family doctor are long gone. So we believe that it is important that facilities allow women to refer themselves for screening.

As you may know, many mammography advocates recommend a baseline mammogram for womenbetween the ages of thirty five (35) and forty (40). This will be used for comparison when a woman is fifty (50) and moving into the increased risk group. The baseline concept is dependent on long-term storage of records yet one out of every six of the clinics we surveyed did not keep records indefinitely. This has led the National Women's Health Network to urge our members and the public to always request a personal copy of one's mammogram.We commend Representative Stark for drafting legislation which requires indefinite storage.

Our fourth discovery was that facilities calibrate, or measure radiation dosage, of their machine on a set time schedule. For some that means once a year regardless of how many times that machine has been used. Other, more responsible programs, check dosage levels monthly or after a set number of uses. We would strongly recommend that the guidelines used to implement this bill require that compensated facilities use a phantom breast which measures accuracy and that the dosage of radiation is calibrated by trained technicians on a regular and frequent basis.

And last, the National Women's Health Network would urge the committee to bring the expertise which has been developed by the National Cancer Institute to the public through this legislation. More explicitly, we suggest that the outstanding work that NCI has done in developing guidelines to lessen women's risks of cancer of the breast and the high quality materials they have produced be integrated in mammography programs. It has been suggested by knowledgeable researchers that as many as half of the breast cancer cases in the United States could be prevented if American women shifted their eating habits. We have enclosed a copy of a study reviewing the research in this area. The American Cancer Society has also adopted this as a health education campaign. It's obvious that mammography facilities are a perfect outlet for distributing such crucial information.

You can thus imagine our dismay to learn that while many clinics had American Cancer Society booklets on the advantages of mammography, only three clinics provided materials which mentioned the role of a low-fat diet. Since lowering one's fat intake is the only known way to prevent breast cancer, we believe women must be fully informed. And that is why the National Cancer Institute and the American Cancer Sociey have written booklets and handouts which could be used in the setting of a mammography clinic. We have the information in a popular format, please lets put it in the hands of those most interested, women who are at risk for breast cancer.

Further a number of clinics do not teach breast self exam nor do they provide women with written information explaining how it is done. Yet every expert here today would probably concur that monthly breast self exam is an important element of early detection and that we can't solely rely on mammographic screening to catch every breast cancer. Women must be involved in taking care of their health.

We of the National Women's Health Network urge that Congress not stop with offering to pick up the tab on mammography. The women of America deserve better care and all taxpayers deserve to get their money's worth. Implementation of this bill needs to include 1) a requirement that clinics accept women without a doctors referral 2) a requirement that clinics adhere to accepted calibration schedules and 3) a requirement that clinics make available written information on breast self examination and dietary fat. These common sense requirements are simple, inexpensive and do not necessitate amendments to the bill. This is the real bottom line, saving women's lives from breast cancer.

Thank you.

Chairman **Stark**. Thank you very much. Mr. Maxwell.

## STATEMENT OF ROBERT MAXWELL, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY STEPHANIE KENNAN

Mr. **Maxwell**. Yes, sir. Senator, I am Bob Maxwell, president of AARP. I guess last month our membership topped out at 27 million. I really feel this is an opportunity to discuss the concept of preventative health care under Medicare.

With me today is Stephanie Kennan of our Federal affairs department.

As you know, Medicare does not normally cover preventive health services. We once accepted the idea that sickness was part of the aging process. There was a widespread belief that by age 65 one had or had not jeopardized your health. Happily that idea is changing. With increased life expectancy many older Americans want to remain active long after the traditional retirement age. However, as the number of older Americans increases the health status of the elderly will impact the number of hospital or nursing home beds needed, the number of doctors needed and how other health care resources are used.

A recent study by the University of Southern California suggested that older Americans are not getting any healthier despite a dramatic drop in their death rate. Indeed the study showed that the general health of people age 75 and over remained the same from 1970 to 1980. In the 65–74 age bracket, the number of people in poor health increased 5 percent. During the same period the mortality rate for older Americans dropped by about 15 percent.

Until recently little attention was paid to health promotion or preventive health services for the elderly. Preventive services for the elderly even those in their seventies and eighties are now being justified on many grounds.

Diseases such as hypertension, heart disease and breast and colon cancer can be prevented through changes in behavior and or environmental factors. Small gains in health or even a reduction in the rate of decline may make a major difference in the elderly person's quality of life or degree of dependency.

However, the success of disease prevention efforts rests on the individual being well-informed about what steps to take and eliminating barriers to care for individuals. I am very happy to have been on after my copanelist here because she made these very same points.

[The statement of Mr. Maxwell follows:]

## Statement of Robert Maxwèll, AARP Vice President

Good afternoon, Mr. Chairman. My name is Bob Maxwell I am Vice President of the American Association of Retired Persons (AARP) which represents over 27 million Americans over the age of 50. We are very pleased to have this opportunity to discuss preventive health care under Medicare.

The goal of prevention of disease should be a hallmark of our health care system. Few would disagree that ensuring our citizens longer, healthier lives ought to be a major concern. These are desirable goals unto themselves. Moreover, in this era of cost consciousness the question of whether prevention can also reduce health care costs makes it even more an issue.

Prevention activities can take many forms. For example, healthier life styles and emphasis on safety and consumer protection have certainly contributed to improvements in life expectancy. New treatments and technology in the health care area also are factors.

The topic of this hearing---tests and procedures to detect and treat illness at an early stage---represent yet another dimension of prevention. And it is here that the question is usually posed of whether the costs of such medical care are offset by the otherwise higher costs of increased morbidity. This criterion may be an intellectural trap, however. Benefits of prevention often do not show up for many years. And even when they do, they may ultimately raise health care costs when individuals live longer. These successes of prevention could thus be viewed as "failures" to save costs if viewed in too narrow a context. We must guard against using only short run cost savings to the federal government as a guide.

Nonetheless, this should not be taken to mean that any test or any procedure that might ever have a beneficial effect should be undertaken. A balance is surely needed, and we would not counsel a system that provides incentives to overuse medical care. Studies are now showing that some inappropriately medical care is now delivered, raising health care costs while providing no benefits. Thus, some accountability is certainly necessary.

The issues of prevention for older Americans require particular sensitivity. As you know, Medicare does not normally cover preventive health services. We once accepted the idea that sickness was part of the aging process. There was a widespread belief that by age 65 one had or had not jeopardized their health, and little more could be done. Fortunately, that idea is changing. With increased life expectancy, many older Americans can remain active long after the traditional retirement age.

Sadly, a recent study by the University of Southern California suggests that older Americans are not getting any healthier despite a dramatic drop in their death rates. Indeed the study shows that the general health of people age 75 and over remained the same from 1970 to 1980. In the 65-74 age bracket, the number of people in poor health increased 5%. During the same period the mortality rate for older Americans dropped by about 15%. Until recently little attention was paid to health promotion or preventive health services for the elderly.

Diseases such as hypertension, heart disease and breast and colon cancer can be prevented though changes in behavior and/or environmental factors. And small gains in health or even a reduction in the rate of decline may make a major difference in the elderly person's quality of life or degree of dependency.

Yet, the Medicare program is oriented toward treating the actute care crises rather than preventing such consequences. This orientation places an emphasis on expensive treatment at the exclusion of less technological, less expensive services. Offering Medicare reimbursement for preventive services would be a major step in reorienting patients and their physicians to place greater emphasis on prevention and early detection rather than on diagnosing and treating the disease after it has progressed to a more advanced and often more costly stage.

Lack of insurance coverage for such services may act as a particular barrier to those with low incomes. A recent Robert Wood Johnson survey found that while all Americans are reducing their use of medical care, the poor and minorities suffer most from the continuing escalating cost of health care. Of those with chronic illnesses such as cancer, diabetes and heart disease about 20 percent had not seen a doctor in a year.

While the value of some preventive tests has been controversial, mammography is one area in which the data demonstrating its success has been proven. Additionally, PAP smears have been proven effective in detecting treatable cancer. At present 41 percent of all cervical cancer deaths occur in elderly women.

A 1986 Gallup poll showed that 82% of women over 40 do not follow accepted guidelines on the regular use of mammography. The cost of mammography ranges from $100 to $250 and it is this cost that is considered a major barrier. An individual who feels in good health will see the prospect of paying $100 or more out of pocket as an enormous barrier. Most insurance policies do not cover screening mammograms which can detect problems at the earliest and most curable stage, even though physicians recommend that women over 40 get mammograms once a year. Diagnostic mammograms used when some suspicious condition occurs are usually covered.

In 1984 this country spent $2 billion on health services to treat breast cancer. Medicare paid about $680 million of that sum. Periodic screening would permit us to detect breast cancer at an earlier and less costly stage of the disease. But even more important, earlier detection contributes to the quality of life of that individual, something that cannot be measured in scientific terms. Prevention that raises the quality of life is a legitimate goal even if federal cost savings are not apparent or occur over a long period of time.

AARP believes that the first step in including preventative services under Medicare should be a service which would provide the most good to as many beneficiaries as possible. While mammography may be such a first step, it should not be done to the exclusivity of any other service that could provide a larger good. Moreover, we must carefully weigh all the benefits of coverage against the competing demands for coverage of the more catasrophic expenses. Your legislation to provide Medicare coverage of mammograms on an assignment related basis and to cap the reimbursement at $50 is a good proposal. We know that when done in high volume the amount charged for this service drops without sacrificing quality.

AARP is mindful that costs to the Medicare program may occur in the short-term. However, the long-term costs associated with breast cancer can and should be presented.

AARP looks forward to working with you in addressing the need for preventive health care in Medicare.

Chairman **Stark**. Mr. Maxwell, I agree with your testimony in terms of preventive care, but I am having a little trouble deciding whether AARP is with us or against us. On the one hand you suggest it is necessary, which I think we all agree on, but on the other hand you don't want us to do it.

In effect, what I am interpreting is that we are going to prevent other services. Now, I have had this conundrum presented to me by the AARP in the past with catastrophic and other issues, and it is of serious concern to the committee. We are certainly not experts. We have got two ways that we can look towards providing medicare services.

One is to the professional community who may suggest to us with statistics that there are certain services that are more critical because more people are dying or getting sick and second, there are the beneficiaries who for the most part are senior citizens. Some of us might expand this but for now, the question is, and I hate to push AARP——

Mr. **Maxwell**. Push us.

Chairman **Stark**. When you claim to practically represent all 30 million Medicare beneficiaries, you have got to choose, you can't have everything. Which do you want? Because you can't come back mad at me later saying, damn, you didn't put free aspirin in there because you spent all your money on mammography.

That is why I am asking you that, and I know it is difficult because you are going to make half your members mad or maybe even only a third. I don't know where it breaks down. So what do you think? Do you think this is one of the two top priorities in preventive services?

Mr. **Maxwell**. I think we definitely think it is an important one. The only concern we have, Senator, is that we——

Chairman **Stark**. Just Congressman. Don't promote me right out of work. You will give Pete Wilson heart failure.

Mr. **Maxwell**. I should have said Mr. Chairman.

I think the problem that we are concerned about is what will do the greatest. My suspicion is as we look at the statistics—by the way I made a parenthetical statement there and cut off half of my testimony, but you have it before you, you have read it.

Chairman **Stark**. Yes, sir.

Mr. **Maxwell**. Our concern, I think, is yes, we think mammography is very important and we certainly support your bill. The thing that we are—our concern is let's not neglect some of the other things that may be part of the job. Now, we heard previous testimony today saying maybe we should be talking about a minimum general examination to be supported by Medicare. And by the way, I would like to insert the concept that if we save many of these people, as the statistics showed on the chart over here, many of those people may make an economic contribution to the ongoing of this country.

They don't—we are not just preserving them to be nursing home residents, and I think as we look at the older population they are beginning to assume more and more of a contributor position, and so while I think that the concept of prevention—I, by the way, am a fire prevention engineer. We reduce fires to prevent the cost of insurance. We can prevent illness and cancer and prevent the terrible subsequent cost on a person's life. So it seems to me, yes, there is a return in preventative medicine and that is exactly what your bill is addressing. How we quantify it is very difficult. But I am certain that it is there.

Chairman **Stark**. Have you given any thought to—if this isn't that marginal cliff we will fall over—what will happen when we come down the road paying for some services under the catastrophic bill which looks like some form or another will become law?

But let's suppose that the catastrophic bill is all we got. Let's suppose the well runs dry and the President threatens to veto everything else. How does AARP suggest we pay? Have you come up with any conclusions as to how you think we ought to pay for it?

Mr. **Maxwell**. Pay for your——

Chairman **Stark**. Or additional preventive benefits, annual physicals, and so forth? As we add this list of things—you know, adding benefits is my favorite sport around here, paying for it is not exactly the joys my mother told me were attendant to this job.

So that is my problem. I have a lot of fun with dessert, I just don't like spinach.

Mr. **Maxwell**. My feeling is what we are trying to do is integrate the two.

Ms. **Kennan**. We are very, very well aware of the cost of catastrophic and the fact they are paying for it themselves. As you know, the Senate version has a very large preventive health care amendment tacked on to their bill. I think we are going to have to make hard choices when we come to what is finally on the catastrophic bill.

We know in the coming years we are going to have cost saving ideas, such as physician payment reform. We don't want to load up the Medicare system so that it breaks the bank and we are very, very conscious of that.

We think there are some steps that need to be taken which may save us. I know the CBO and HCFA costing trap. We have been through it several times with you.

I couldn't give you a yes or no, whether something should be on future reconciliation or catastrophic.

I would like to get back to you in writing with a specific answer on that.

Chairman **Stark**. Okay. I guess I would ask Miss Pearson, then Mr. Maxwell, as a final question, you talked about not just allowing mammography to stand alone, but to make sure that as long as we are doing the job we don't just do 90 percent of it, we do 100 percent of it, do as much education as we can.

How do both of you feel, Miss Pearson and Mr. Maxwell, about the theory that the Federal Government ought to push if not coerce, entice, whatever word you want to use, our seniors under the Medicare program, for those who don't get into capitation, to have to go and have some kind of annual checkup, if to do no more than to fill out a form, to kind of force people to do what is good for them?

Any thoughts about that?

Miss Pearson.

Ms. **Pearson**. I——

Chairman **Stark**. Not mandatory drug testing.

Ms. **Pearson.** My first thoughts were the thoughts that we probably all have when other issues are grabbing our attention in the headlines, confidentiality of test results and where does that information go. I think it is reasonable for the Federal Government to encourage people who are receiving benefits under a federally funded health program to get routine checkups if that is the example you want to use.

I think since we are dealing now with a group of people who possibly more than those who lived through the changing views of participating in their own health care and becoming a knowledgeable partner of their health care provider—I think we should be sensitive to people who wish to refuse certain screening tests and not penalize them.

But I would be willing to feel comfortable with some sort of encouragement to at least come in for the regular exam.

Mr. **Maxwell.** I think the very nature of our organization is one of being an educator, and it would seem to me there should be a combination thrust from organizations like ours and HCFA urging people, but, gee, I am afraid we would be called socialized medicine people and everything.

Chairman **Stark.** Let's stop for a moment. If you go into an HMO, let's suppose you turn 65, you go to sign up for Medicare and instead of just mailing you a form we said, no, before you can be in Medicare you have to get your Social Security check and Medicaid card, and you have to fill out a form. They ask you all the little questions they ask in a physical exam, and then perhaps Medicare would require someone to have—or to suggest to them, to have the physical exam.

You ought to be able to get them there once. What would be wrong with saying when you get into the Medicare system——

Mr. **Maxwell.** That is exactly why I am not a member of the HMO.

Chairman **Stark.** You don't want to take the test. Are you scared of doctors?

Mr. **Maxwell.** I am a four-way bypasser and I am afraid they wouldn't be very happy with me coming in.

Chairman **Stark.** I am not suggesting it would keep you out of Medicare. I am saying at some point the professionals, who I presume are trained in this, could at least encourage people to have preventative tests.

They could ask them—have you ever had a mammography exam?

And, if not, they could hand them a brochure and say go get one at such and such a hospital, it is free and you ought to do it.

It might scare them into doing it.

Ms. **Pearson.** For women who attend family planning clinics, they are required to get an exam every so often to get whatever method of birth control they are using.

I happen to be in an age group that lives with that requirement. I have older relatives who aren't and I have seen them react to some of the changes in regulation of health care by the Government.

For example, requirements that you must consent up to a month in advance for sterilization; older women ask, "what is the Government doing in my life, why do I have to sign these forms?" It is a question of education. I don't want to go on record saying the Government should require every person over 65 to do this, that and the other.

I think we can combine your suggestion of urging with an education campaign making the distinction between the government nosing into your health and the situation everyone is familiar with—kids don't get into schools without immunizations.

Chairman STARK. I gather that is now required. We stuck in there.

I want to thank both of you. It is my hope that in the next couple of months we find a way to add this benefit to the program and I hope it doesn't prejudice other benefits your organizations and the women's health group would like to see.

I am sure this is just touching some of the things we must do in the future.

I thank the witnesses very much for their participation today, and the meeting is adjourned.

Mr. MAXWELL. By the way, we think the 50 bucks is a good price.

Chairman STARK. Okay.

[Whereupon, at 4 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

# Statement

# of

# The American College of Radiology

# on

# H.R. 3576 - Medicare Coverage of Mammography Screening

# For the record of the Ways and Means Subcommittee on Health

# November 3, 1987 Hearing

The American College of Radiology supports coverage under Part B of Medicare for screening mammography. The ACR believes that the mammographic procedure is highly safe, reliable and acceptable to the patient and can be definitive in early diagnosis of benign and malignant breast conditions. We also believe that the mammographic procedure should be performed by physicians uniquely trained and qualified, using radiographers specially trained and using equipment specifically designed for mammography. The ACR recognizes the concern over the issue of cost of screening the Medicare population. The ACR has encouraged its members to make mammography available to all patients at a reasonable cost.

The ACR recommends that at the age of 40, a woman receive base-line screening mammograms and between the ages of 40 and 49 have mammographic screening every year or two. The College recommends that at age 50 a woman have a mammogram every year. The College believes the use of mammographic screening facilities is an initial step in breast cancer detection and encourages its members to set up screening facilities where women can obtain a mammogram without the referral of a physician and in which costs would be kept to a minimum. The basis of this position is our belief that mammography is capable of providing the diagnosis of carcinoma of the breast prior to its speading outside the breast and that treatment applied at this stage can, predictably, produce a cure rate above 90 percent.

The ACR recommends that radiologists interpret mammograms. Radiologists are uniquely qualified to perform mammographic screening. They possess the expertise of imaging equipment, receptor systems, radiation physics and dosimetry, plus understanding of the anatomy of the breast. Mammographic screening should be performed under the supervision of a radiologist with demonstrated experience and competence in mammography. Expertise is needed in the actual imaging and interpreting the images.

Radiologists completing their training in the past 10 years received formal training in mammography. Continuing education classes, like those offered by the ACR, provide training in new modalities and changing technologies. Radiologists not orginally trained in these modalities or technologies raise their competence rapidly and thoroughly upon completion of these classes.

The ACR is concerned that facilities and physicians providing mammography provide the examination ensuring that women receive optimum mammographic examinations with the lowest possible risk. As a result, the ACR has established a program for accreditation for mammography facilities. The voluntary program provides members the opportunity for peer review and evaluation of their facility's staff qualifications, equipment, quality control and quality assurance programs, image quality and breast dose. Those institutions meeting all of the criteria are awarded a three year accreditation, a certificate for each approved mammography unit and a listing on the American Cancer Society's referral list of approved mammographic centers.

AMERICAN COLLEGE OF RADIOLOGY
1891 Preston White Drive, Reston, Virginia 22091 (703) 648-8900

H.R. 3573 provides for Medicare reimbursement for mammography screening on an assigned basis only and limits Medicare's share of the cost of the examination to $50. The ACR believes that reimbursement for mammography screening can be developed in conjunction with the recommended program for development of a radiology relative value scale for payment purposes under Part B of Medicare, which was supported by the Subcommittee. The ACR provided the Subcommittee with its position statement on reimbursement for radiology services under Medicare at the Subcommittee's hearing on May 13, 1987. The ACR is opposed to mandatory assignment, though we have encouraged our members to take assignment when they feel it appropriate to do so.

In summary, mammography has made a highly significant contribution in the detection of breast cancer in women. A mammogram performed under the supervision of an experienced radiologist coupled with a clinical examination has literally made the difference between life and death in thousands of women. The challenge remains to make mammography available to as many women as possible. The American College of Radiology supports the efforts of the Subcommittee to provide the benefits of this important screening to Medicare patients.

# TESTIMONY OF
# KAREN ANTMAN, M.D.

Clinical Director of Solid Tumor Autologous
Marrow Program and of the Sarcoma Service
at the
Dana-Farber Cancer Institute
Harvard Medical School
Boston, Massachusetts

Chairman of the Public Issues Committee
On Behalf of the
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

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## Medicare Coverage for
## Annual Mammography Examinations

The Honorable Fortney H. Stark, Chairman
Subcommittee on Health, Committee on Ways and Means
U. S. House of Representatives

## Background on ASCO

The American Society of Clinical Oncology, founded 24 years ago, is the nation's largest organization of specialists providing cancer patient care, conducting clinical cancer research and training cancer physician specialists. Approximately half of its members are practicing physicians involved directly, or as consultants, in the care of the majority of the nation's cancer patients in offices, and community and university hospitals, and half are engaged in research and training in literally all of the nation's schools of medicine, cancer hospitals, centers and institutes. Its members include the nation's leading physicians in medical and pediatric oncology, radiation therapy and surgical and gyncologic oncology, and also basic scientists in pathology, immunology, pharmacology, and biostatistics. Collectively, this society represents the nation's major resource of specialists in the diagnosis and treatment of cancer patients, the application of research to cancer patients and the training of the cancer physicians and clinical researchers of the future.

## Statement of Support

We strongly support Chairman Stark's proposal to provide Medicare reimbursement for an annual mammogram.

Mammography is almost unique among screening procedures because its effect on cancer mortality has been evaluated via a controlled trial.

The Health Insurance Program study (1), done during the 1960's, randomized 31,000 women aged 40 to 64 years. Those receiving yearly screening mammograms had a mortality due to breast cancer 30% below that of the control group. In the Health Insurance Program study, 38% of the cases of breast cancer detected on initial screening were discovered by mammography alone. In this study, using older radiologic techniques than are available today, the detection rates (sensitivity) were low by today's standards. Nevertheless, the sensitivity of mammography and physical examination for detecting breast cancer were 62% and 24%, respectively. The sensitivity of the two methods combined was 75%. 81% of small tumors (under < 1 cm), were detected by screening.

In the Breast Cancer Detection Demonstration Project (BCDDP) (2), approximately 275,000 women had periodic breast cancer screening. Of 3,557 cases of cancer detected by screening, 42% were found only by mammography. Among the 148,223 women examined in the first screening, 734 cases of cancer were detected and proved by biopsy; 322 of these were in patients with negative physical examination. Seventy percent of the patients with cancer had negative axillary lymph nodes. About one-third of the tumors were less than 1 cm. Of all the breast cancers detected in the first screening, 234 (32%) were in women less than 50 years. The incremental value of mammography is shown by the fact that if mammography had been omitted, 63% of the minimal breast cancers would have been missed as compared to 16% for physical examination. As a result, the American College of Radiology and the American Cancer Society have extended their recommendations to include screening of even younger asymptomatic women ages 40 to 49.

Therefore, it is clear that mammography can be an excellent preventive medicine technique.

## Guidelines, Equipment and Personnel

We are aware that H.R. 3573 requires the Secretary of Health and Human Services to establish conditions of participation for facilities where mammographies would be performed. We would suggest that the legislation also indicate that appropriate regulations be developed for standards of equipment and use, guidelines on the level of training of personnel using the equipment, and guidelines for appropriate examination of the films obtained.

The American Society of Clinical Oncology stands ready to lend its expertise to the Secretary to develop such appropriate guidelines.

1. Shapiro S. Venet W, Strax W, Roeser R. 10-14 year effect of screening on breast cancer mortality. JNCI. 1982;69:349-55.
2. Baker LH. The Breast Cancer Detection Demonstration Project. Cancer Journal for Clinicians. 1982;32:194-225.

# TESTIMONY OF

## ALAN C. SARTORELLI, Ph.D.

Alfred Gilman Professor of Pharmacology and
Director, Yale Comprehensive Cancer Center
of the
Yale University School of Medicine
and
President, Association of American Cancer Institutes

## Medicare Coverage for Annual Mammography Examinations

The Honorable Fortney H. Stark, Chairman
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

The membership of the Association of American Cancer Institutes consists of 74 of the leading Cancer Centers of this nation. The Cancer Centers program was established after the passage of the National Cancer Act in 1971. The report language accompanying the Act states that "Cancer Centers can play a major role in the conquest of cancer by (1) performing fundamental research in the clinical and non-clinical disciplines, (2) serving as lead organizations in planned and coordinated major cancer (organ site) programs, (3) performing a particular segment of a major program component in which they have special competence, (4) providing specialized research and/or clinical capabilities, (5) serving as focal points for testing and evaluating outputs of the cancer research program efforts to medical practice."

These objectives are being met by the network of Cancer Centers which are working towards the stated goals of the National Cancer Institute to reduce cancer mortality by 50% by the year 2000. The Association of American Cancer Institutes strongly supports Congressman Stark's proposal to include an annual mammogram as part of Medicare coverage, since this technology will contribute significantly to a reduction in mortality from breast cancer.

Mammography has been shown to be the most sensitive modality currently available to diagnose early breast cancer, being capable of detecting over 90% of cancers. Early diagnosis of breast cancer is extremely important, since tumors discovered in an early stage of development are the most easily treated. Yet this technology is grossly underutilized, with only 10 to 14% of physicians sending their patients for annual mammograms. This is partly due to the high cost of the current procedure and to the lack of public awareness. These obstacles are not insurmountable.

A series of studies have shown that the routine use of mammography to screen women without symptoms of breast cancer can reduce the death rate from the disease by at least 50% (Collette et al, 1984; Shapiro et al, 1985; Tabar et al, 1985a, 1985b; Verbeek et al, 1985; Palli et al, 1986). Furthermore, early detection markedly reduces the cost of treating breast cancer, with early disease having a treatment cost of $20,000 per patient, while the cost of late stage disease has been estimated to be of the order of $60,000. For these reasons, we believe it is important to the health of Americans to provide Medicare coverage for this preventive procedure. In constructing such a program it is critical that quality control of these examinations be included. The American College of Radiology has established guidelines and processes of review that should serve as standards for monitoring (a) the quality and the calibration of the x-ray equipment and (b) the expertise of the individual interpreting the films.

## References

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Tabar, L., Fagerberg, C.J.G., Gad, A., et al. Reduction in mortality from breast cancer after mass screening with mammography: randomized trial from the breast cancer screening working group of the Swedish national board of health and welfare. Lancet 1:830-832 (1985a).

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Palli, D., Del Turco, M.R., Buiatti, E., et al. A case-control study of the efficacy of a non-randomized breast cancer screening program in Florence (Italy). Int. J. Cancer 38:501-504 (1986).

# STATEMENT
# OF THE
# HONORABLE CARDISS COLLINS
# ON
# MEDICARE COVERAGE OF MAMMOGRAPHY EXAMINATIONS

Mr. Chairman:

As the first Member of Congress to introduce legislation this session requiring Medicare coverage of mammograms and Pap tests, I should be pleased by the scheduling of this hearing. Instead, I am deeply disturbed because the House in general, and this committee in particular, already missed an excellent opportunity to act on this critical issue.

This past summer, the House Subcommittee on Health and the Environment unanimously approved an amendment I offered to the catastrophic care bill requiring coverage of mammograms and colorectal tests. This change in coverage was made because Pap tests are relatively inexpensive, whereas colorectal tests are considerably more "catastrophic" in cost. My amendment ultimately was included in the catastrophic care bill reported out by the full committee.

Given the opportunity to take the lead in making a dramatic shift in Medicare, from covering people who are already sick to paying for tests for the early detection of diseases, my amendment should have been included in the final version of the catastrophic care bill. However, it is my understanding when the Energy and Commerce and Ways and Means Committees negotiated over the terms of this bill, my proposal was deleted at your committee's request.

Notwithstanding this shortsightedness, I am pleased to report the Senate last week adopted a proposal by Senators Robert Graham and David Durenberger that would provide Medicare coverage for a range of preventive tests, including mammograms, Pap tests and colorectal tests.

As a likely House conferee on the catastrophic care bill, Mr. Chairman, I hope you will encourage the House to recede from its position and accept the Senate amendment.

If you need support for this position, consider these national statistics from the American Cancer Society -- 131,000 new cases of breast cancer and 145,000 new cases of colorectal cancer will occur this year. More tragically, 41,000 women will die of breast cancer and 60,000 people will die of colorectal cancer in 1987.

Notwithstanding these compelling statistics, some will argue that my legislation is too costly. According to an estimate from the Congressional Budget Office, this proposal will cost $30 million in 1989 and $50 million in 1992 to implement.

Many have labeled this legislation as one relating to "prevention" and I beg to differ with them. Having a mammogram, or colorectal test, does not prevent cancer. It provides early detection of cancer!

Admittedly, no one has calculated the actual dollar savings we could achieve if people took the preventive steps recommended by my bill. However, in the case of breast cancer, a Texas physician provided the State Legislature there with hospitalization figures for treatment of this cancer, excluding the cost of a mastectomy. Her figures ranged from $11,000 to $60,000! By comparison, the cost of having a mammography ranges from $125 to $175. I wholeheartedly agree with the conclusion of this physician who said:

> (i)f we took the 'lowest' figure from my report and added even a portion of the above costs, the most conservative total would be a fraction of what it would have cost to screen the same woman on an annual basis and to have treated her cancer at an earlier, and therefore curable stage. (emphasis added.)

Similarly, in the case of detection of colorectal cancer, I believe the potential savings could be equally significant. A stool blood test costs $20 and a sigmoidoscopy costs $195. By comparison, an initial hospital stay for treatment of this cancer costs nearly $2100!

My legislation gives Congress a significant opportunity to reverse the statistics cited above. A study done of a screening program offered by the Health Insurance Plan of Greater New York indicates there could be a thirty percent reduction in breast cancer if screening were done on a regular basis. According to the Cancer Society, the five year survival rate for early detection of colorectal cancers is ninety percent.

If you still have doubts, consider the intangible benefits that we will provide people. How many will be spared painful, debilitating surgery? How many will have their lives prolonged? Under current survival rates for colorectal cancer alone, the Cancer Society estimates one hundred thousand people, versus the current sixty thousand people, could be saved if more people took advantage of early detection procedures. That's a difference of forty thousand people! Aren't the lives of these people worth $30 to 50 million?

Mr. Chairman, I hope you and the members of your subcommittee will not only consider these statistics in evaluating the merits of this legislation, but, most importantly, in forming your conference position on the catastrophic care legislation.

NABCO
NATIONAL ALLIANCE
OF BREAST CANCER
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Statement to be Presented at Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, November 3, 1987
The Honorable Fortney H. Stark, Chairman

October 29, 1987

Dear Mr. Chairman:

The National Alliance of Breast Cancer Organizations ("NABCO") and its 135 members wishes to go on record advocating Medicare coverage for Mammography examinations.

As the Subcommittee noted in its background brief for this hearing, breast cancer has reached epidemic proportions in the United States. With one of 10 women developing the disease sometime in her life, and 40,000 deaths annually, there is no disease that more women spend more time thinking and worrying about than breast cancer.

As yet, there is no cure for breast cancer, but early detection offers women the best chance for survival. When the cancer is found at its earliest possible stage -- before it can be felt as a lump -- survival is assured an encouraging 95 percent of the time. Sixteen-year results from a Health Insurance Plan trial show that such screening reduces mortality by about one-third in women 50 to 59 years old; early results from a similar trial in Sweden support these conclusions.

A major thrust is now underway nationally to change the attitudes of women and their doctors about mammography, a diagnostic tool that can detect a breast tumor when it is not much larger than a period on this page. Despite its proven potential to help save lives, mmammogaphy remains one of the most underutilized of medical tests. Only 15 percent of the women who should be mamographed avail themselves of this potentially life-saving test. The reasons certainly include the high cost of mammography and the absence of Medicare and third-party insurance coverage, as well as fear of mutilation should a malignancy be discovered and lack of education regarding options for less drastic surgery for small tumors.

NABCO, a not-for-profit organization, is the nation's central resource of information on breast cancer. We and our members constantly work to support legislation that would make routine screening mammography a reimbursable procedure. We would welcome the opportunity to discuss with you NABCO's efforts, which are so important to women everywhere.

Yours sincerely,

Ruth A. Spear.

Ruth Spear
Executive Director

**NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE**

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# STATEMENT OF
# FORMER CONGRESSMAN JAMES ROOSEVELT
# CHAIRMAN OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four and a half million members. The vast majority of our members depend on Medicare for their primary health insurance protection.

Mr. Chairman, I want to commend you for introducing legislation and holding this timely hearing on the expansion of Medicare to pay for preventive mammography screenings.

> **The National Committee strongly supports legislation to expand Medicare to pay for preventive mammography tests as well as other preventive tests.**

Preventive care can be the most effective means of averting more serious illness and unnecessary deaths. Medicare's failure to pay for preventive care is shortsighted. Your leadership is welcome.

Breast cancer is a devastating health problem for many women. It is estimated that 1.5 million women currently have or have had breast cancer and live in fear of recurrence. There are 120,000 new cases annually, and as many as 40,000 women die of this disease every year. In fact, breast cancer constitutes one of the worst threats to women's health and welfare. One woman in ten gets breast cancer and experiences the terrible fear of physical disfigurement, illness and death. According to a House Select Committee on Aging report, on the average breast cancer robs women of 20 years of their lives. Women dying of breast cancer at age 65 and older could have lived an average of 12 more years.

Fortunately, modern medicine has developed the important technology of mammography to help detect breast cancer at an early stage. Mammography has been proven to be very effective. One study, the Breast Cancer Detection and Demonstration Project, showed that routine screening reduced mortality by 42 percent. It is so effective because the mammogram can pick up small masses in the breast as early as three years before a doctor can detect such areas by palpatation.

It is indeed shameful that Medicare and most other forms of health insurance will pay for mammography for diagnosis, but not for prevention. Before you reach diagnosis, a breast mass has to be a size that can be detected by the physician. At this stage it may be too late for some women because the cancer has spread.

Modern technology including mammography is only effective if it is used. At the cost of between $100 and $200 for a screening procedure, many women cannot afford the annual preventive tests recommended for older women. Considering the cost to the Medicare program for the treatment of patients who die from breast cancer, one has to think preventive care would be cost effective, especially for women with recognized risk factors.

Mr. Chairman, the National Committee urges you to extend Medicare coverage for mammography as well as for other preventive tests.